

LEADERSHIP IN PUBLIC HEALTH: REDUCING INEQUALITIES AND IMPROVING HEALTH

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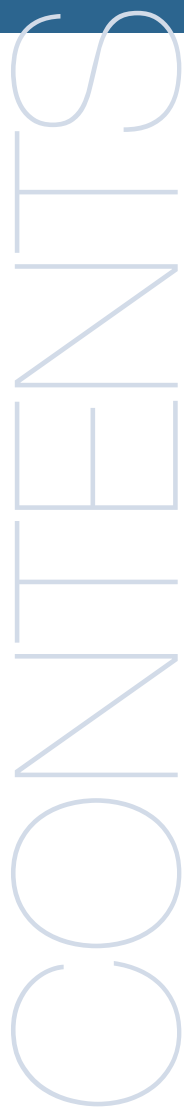
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Featuring viewpoints on the future challenges for health care policy in Europe from:

Alois Stöger, Federal Minister of Health, Austria

Tonio Borg, EU Commissioner for Health and Consumer Policy

Zsuzsanna Jakab, Regional Director of the WHO Regional Office for Europe

Martin McKee, Professor of European Public Health at the London School of Hygiene and Tropical Medicine

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Editorial

This second special Gastein edition of *Eurohealth* marks an important step in the long-standing collaboration between the European Observatory on Health Systems and Policies and the European Health Forum Gastein in an effort to promote a constructive European health policy debate.

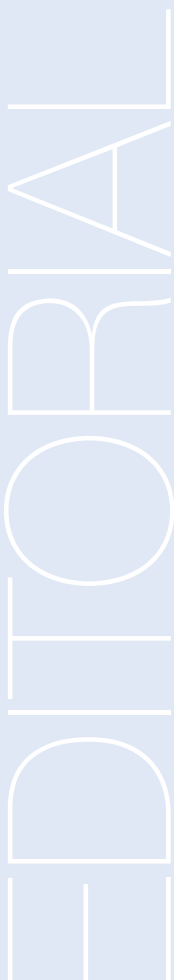
With this year's topic '*Electing Health – The Europe We Want!*' the EHFG speaks to the very core of EU health politics. Debating the EU health mandate is no stranger to the pages of this journal nor is it a new theme for the EHFG. On the contrary, year after year the Forum has succeeded in providing a unique platform for exploring policy innovations and legal developments and for fostering forward thinking and decision making among key health policy constituencies in the EU. At the risk of sounding too optimistic, there is now a sizeable window of opportunity to adopt a stronger health policy agenda in Europe. While besieged by many challenges, no less by the increasing euro-scepticism in politics or by the threats posed by the financial crisis to the European social model, we believe that many of these challenges can be converted into opportunities. For instance, we can reassert the uniqueness of solidarity as a core European value or demonstrate the centrality of health as an engine for societal cohesion and economic growth. In the same way, the EU counts on an increasing arsenal of legislation, policy strategies and instruments to make this possible, such as those arising from *Europe 2020*, the European Semester cycle for economic and fiscal policy coordination, the Cross-border Care Directive or, more recently, the Commission's Communication on effective, accessible and resilient health systems. While most, if not all, are born out of 'economic union' policies with a main objective of fostering economic growth, strengthening the internal market and supporting financial sustainability, they may not offer the sole but perhaps the best chance to boost an EU health agenda.

Similar to last year's edition, the EHFG 2014 poses four challenging but very policy-relevant questions to its delegates. In a nutshell, we are asking delegates to gaze into the crystal ball and share our 'vision' of: the future of the European social model and its core values; the EU's future role in health and health systems; the 'nuts and bolts' of implementation

i.e., what policy frameworks and instruments are needed for the EU to fulfil this new role; and, chiefly, how the EU can contribute, in practice, to improving the performance of health systems in Member States.

The main bulk of the articles in this special issue of *Eurohealth* reflect on the themes of the EHFG 2014 parallel forum sessions and provide us with some very insightful responses. In the lead article '*Health and European integration: part of the problem or part of the solution?*', Brand and Palm address the central question of this year's Forum by placing health at the centre of the *Europe 2020* growth strategy, with the trinity of wealth, economic growth and budget sustainability making up its constituent dimensions. Without quibbling about the 'holiness' of such a Trinity, we do agree with the authors that the role of the EU in health is much broader than that given by the public health article in the Treaty. Yet, this should not stop policy makers from seeking ways to strengthen the health mandate and/or implementing it more effectively, such as by championing 'Health in all EU policies'.

The 'European Voices' section provides an appetiser for responses from a selected panel of key stakeholders in European health policy representing the four constituent pillars of the Forum. Notably, with the exception of Professor Martin McKee, who shows a healthy dose of academic scepticism, all other stakeholders including the European Commission, World Health Organization (WHO) and the Austrian Minister of Health, as well as patients and industry representatives, seem to share a fairly positive outlook on the future of health in the EU and agree on many of the policies that need to be put in place. The "Voices from Parliament" heard in this issue echo that sense of hope and optimism regarding the role of health in European policy-making and the priority it deserves in the course of the next term – not least for its impact on economic performance.



These ‘voices’ the universal access health systems as a cornerstone of the European social model and a unique strength of the EU; a view which is echoed by many of the contributors in this issue. Both the papers by Furtado et al (European Commission Directorate-General for Health and Consumers) and Emiroglu and Kasapi (WHO Regional Office for Europe) emphasise its importance in shaping the global health agenda and in particular the post 2015 development agenda. Indeed, the WHO-led global universal health coverage movement joined by many countries, not least the US, underlines the important leadership of Europe in this field. If anything, Europe is called to play a greater and more assertive role in global health governance, and as Furtado and colleagues argue, the close collaboration, involvement and support of the EU to the WHO global health agenda will be central in doing so.

Perhaps not surprisingly, most contributors to this issue seem to sing to the same tune of increasing the EU’s role in health. Yet, we cannot criticise them for lack of pragmatism nor for ‘preaching to the converted’ – a frequent disease amongst the public health community. For instance, while Rose argues that the EU can, and should, be an agent of change for health, she also highlights that it can only do so if ‘it means business.’ Referring to the unprecedented opportunity posed by the new EU economic governance framework, the article emphasises the need to raise the profile of the health commissioner in the new Juncker college. The commissioner needs to become a key player in the formulation of country-specific recommendations led by the Directorate-General for Economic and Financial Affairs.

The articles in this issue provide a particularly rich set of concrete examples of the kinds of strategies, instruments and initiatives that the EU has at its disposal to fulfil a stronger health role. Perhaps, only the most ardent euro-sceptic would disagree with the EU putting in place pro-competition regulation or promoting innovation in areas such as eHealth or personalised medicine – both acknowledged as key for the EU’s economic growth. The articles by Leyers et al on ‘Europe’s commitment to personalised medicine’ and by Peetso on ‘Telemedicine: the time to hesitate is over’ are both excellent illustrations of this. Similarly, Furtado and colleagues, in their article on ‘Building EU health policy for the future’ demonstrate the benefits of EU-led health partnerships with the private sector and civil society. In the same way, Czipionka, when asking whether and how to reduce the freedom of choice in the new primary health care reform in Austria, draws on the wealth of evidence in many other EU countries that faced a similar conundrum, thus illustrating the benefits of collecting and exchanging rigorous evidence on best practice across EU countries. Blümel et al provide another example of the shared challenge of assuring high quality care while containing costs by illustrating Germany’s latest legislative steps towards not only a more transparent system for patients but also the introduction of quality-related hospital payment. For the 12 former Soviet Union States, on the other hand, there are still many hurdles to take on their rocky road towards improving the quality of care and population health, which according to Rechel et al will necessitate prioritising health on government agendas and spurring on health care reforms.

But ultimately, plagiarising John F. Kennedy’s words, we must ask ourselves not what the EU can do for us but what we can do for the EU to support its health agenda. In that regard, Czabanowska calls for a new model of public health leadership focused on interdisciplinary collaboration to enable the implementation of WHO’s *Health 2020* and of a strong EU public health agenda. However, we also agree with her in questioning how far public health leaders will be willing and able to go in adopting these new roles and tackling pervasive and enduring health inequalities. While the (lack of) reaction of large parts of the public health community to the financial crisis debate has not been terribly encouraging, both Ekman et al and Struckmann et al emphasise the importance of the expert community playing an active role in providing evidence-based research to allow for proactive and person-centred policy making.

Finally, the most difficult question posed by the EHFG is tackled head-on by Wismar and colleagues in the article ‘What is the EU’s contribution to health system performance?’ or, in other words, ‘What can the EU add that the Member States have difficulties in achieving by themselves?’ which constitutes the ultimate stress test for the EU on health. Their article makes a strong case for the EU’s positive impact, with many illustrative examples such as the ‘country-specific recommendations’ (CRC) to reform health systems or the range of legislation on health determinants; cross border collaboration, health professional mobility and European reference networks. But they also point to the challenges posed by the fragmented nature of the EU’s action on health, making it difficult for health stakeholders to be part of shaping EU health policy, particularly when so much decision-making takes place in forums which are not primarily focused on health. We underscore their recommendation to have an informed debate and explicit decision-making by EU leaders on the role of the EU in health and health systems – that should serve as a further spur for discussions at the Forum.

In sum, the articles in this issue provide us with a solid introduction to the evidence and the issues for those fortunate enough to have the opportunity to attend the Forum in the idyllic Gastein valley, but also plenty of food for thought for the general readership of this journal to move one step forward in deciding what is ‘the Europe we really want’ for health.

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HEALTH AND EUROPEAN INTEGRATION: PART OF THE PROBLEM OR PART OF THE SOLUTION?

By: **Helmut Brand** and **Willy Palm**

Abstract: The 2014 European Health Forum Gastein will discuss the future of the European Union's health policy after the recent European elections and the appointment of a new Commission. Where do we stand and what are the real issues at stake? Since the Gastein Forum is traditionally based on the idea of bringing together the various stakeholders in health, including policy-makers, professionals, civil society, industry and academics, we also include initial comments and reflections coming from a panel of key stakeholders in European health policy on the four questions that will be at the core of discussion in Gastein this year.

Keywords: *European Union, Health Mandate, EU integration, European Social Model, European Health Forum Gastein*

Post-electoral stress disorder?

At the end of May 2014, citizens from the 28 European Union (EU) Member States elected a new European Parliament. Despite the attempts to increase its political importance and strengthen democratic legitimacy of EU institutions by linking this election with the appointment of the European Commission's President through the so-called '*Spitzenkandidaten*', the turnout has remained disappointingly low (only 43.09% of eligible voters). On top of that, 25% of the seats went to candidates from euro-sceptic parties.

All of this seems to indicate a disinterest in – if not a mistrust against – the European integration project amongst

part of the European population. As also shown in a recent Eurobarometer survey, trust in European institutions is historically low with an average score of 32% (ranging from 18% in Greece up to 58% in Romania).^[1] However, this is not very different from national politics and in some cases even much better. As Timothy Garton-Ash argued, there are 28 different "shades" of unhappiness – many of them not even EU-related; however, the May 2014 elections are a wake-up call from which Europe may fail to wake up.^[2]

Clearly, an important factor of discontentment has been the financial crisis and the way "Europe" has dealt with it. The European election campaign was dominated by the question of how the

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ongoing economic downturn, as well as the alarming level of youth unemployment in certain Member States can be countered and how to stabilise the Euro. The political debate covered more fundamental issues such as the limits of interstate solidarity, a more focused mandate for the EU to tackle the big problems and a more transparent EU serving the needs of its citizens.

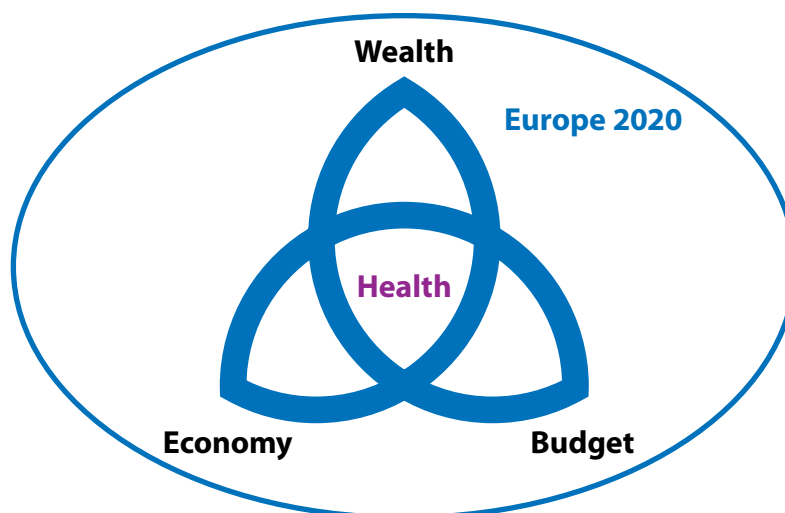
Traditionally, the European project has stood for peace, prosperity and social progress. Now that these noble goals are perceived to have reached their limits – or these achievements are taken for granted – Europe’s cultural, social and political leaders are looking for a “new narrative for Europe”.¹

The EU’s health mandate

At first sight, health is not a topic in all these discussions. However, in all measurements of happiness or quality of life, health systematically ranks high and it is considered a prime concern for many citizens across the EU.² Various studies have demonstrated the devastating effect of the current economic crisis on life quality, also through the deterioration of health, and the growing inequalities and occurring problems of accessibility to health care, especially among more vulnerable population groups such as older people in Central and Eastern Europe and the lowest income classes.³

Health protection is also considered to be intrinsically part of the so-called European social model.⁴ It is striking that when people are asked what values best represent the EU, solidarity and support for others pop up as defining concepts for the European project.⁵ So health could indeed play an important role in reconnecting Europe with its citizens. For this we need some kind of “Roaming for Health” project. Just like the EU effectively addressed excessive roaming charges, it could also help to unlock resources, knowledge and experience in health to the benefit of citizens and patients across the EU. This is essentially what the European Commission has been pushing for within the EU’s health mandate since the Maastricht Treaty in 1992. However, despite the fact that EU actions added positively to various aspects of human health protection, some would

Figure 1: The Trinity of Health: the EU’s approaches to health (systems) as part of Europe 2020



Source: Authors

argue that the legal mandate has been too weak, the initiatives too diverse and the impact too illusive.⁶ Due to the “invisible hand” of subsidiarity, imposed by Member States, EU policy in health could only develop in a gradual and fragmented way, often in response to “health crises”, using a diverse array of – often “soft law” – policy instruments. Even though in this process EU health policy matured to a consistent whole, thanks also to the guiding framework of the 2008 health strategy, *Together for Health*, it remains a rather small issue on the EU agenda. After all, health-related funding through the various programmes (research, structural funds and the health programme) represented only 0.08% of the EU’s budget under the previous multi-annual financial framework (2007–2013).

The Trinity of Health

Still, this is only one part of the picture. In reality, EU health policy is much broader than the health mandate based on the Treaty’s public health article.⁷ Fundamentally, the EU’s approach towards health and health systems is threefold (see Figure 1). In the first place, health is considered an important economic sector, representing, on average, 10% of GDP and 8% of employment and as such is a full part of the internal market. In fact, many of the legislative initiatives that are of direct relevance to the health sector, such as the directives on cross-border care or professional qualifications,

are motivated by the principles of free movement and based on internal market provisions. The second dimension is of a budgetary nature. Health expenses largely also weigh on the Member States’ public budgets and are therefore critical in the context of the EU’s economic governance that aims to guarantee the Union’s economic and monetary stability. Through the European semester we have increasingly seen country-specific recommendations being issued and endorsed by the EU institutions to push individual Member States to reform their health systems and make them more financially sustainable. At the same time, health is also considered as an important factor for economic growth and social cohesion. This is why the Commission actively promotes the idea of investing in sustainable health systems, in people’s health and in reducing health inequalities, with support from EU funds and as part of its social investment package.⁸

Even though these approaches – forming the three dimensions of the Trinity of Health – may sometimes be perceived as contradictory, they all form an integral part of the EU’s encompassing growth strategy *Europe 2020*, which aims for economic growth that is smart, sustainable and inclusive. Still, apart from the European innovation partnership on active and healthy ageing, positive references to health are hard to find in the strategy’s priorities, objectives, indicators or initiatives. The image persists of an

imbalance in the various approaches. Ironically, where Member States often continue to claim subsidiarity to deny a more direct and positive action for health, this does not stop EU economic rules and processes from indirectly impacting on health and health systems.

Good intentions for a new term

So what to do under the new term? What are the priorities that the new European Commission and Parliament should focus on?

Clearly, as the economic crisis seems to turn from an acute into a more chronic condition – or as the Greek health minister put it at the EHFG 2013: *This is not a crisis, this is the new reality* – the social dimension of the EU is to become ever more a critical and essential element of European integration. The challenge that Europe is facing today is nothing less than the resilience of its social model. German Chancellor, Angela Merkel, recently reminded us that in the EU, with 7% of the world's population, we generate 25% of the world's economy but also spend nearly 50% of all social benefits in the world. To keep this will require a great deal of creativity and innovation, she concluded.⁹ This is exactly what has dominated discussions at the European Health Forum over the last few years. Where in 2012 the main question was the effects of the crisis for health, in 2013 the focus turned to how health systems can be made resilient and innovative.

Next to steadfastness in sticking to the values underpinning our health systems, we may also need to explore new forms of health governance that also better facilitate the integration of technological and social innovations. Today, no policy level can claim any longer full exclusivity over health. National, regional and international policy-makers will need to work together more closely and coordinate their actions to achieve better outcomes. This applies in the same way to fragmentation and duplication within the same policy level. In addition, at EU level there is scope for better linkages between initiatives that are undertaken. For instance, to what extent is the valuable work of the Reflection process on modern, responsive and sustainable health systems, set up in 2011,

used to inform the country-specific recommendations that are issued in the field of health system reform? The recent Communication on effective, accessible and resilient health systems is showing the way by compiling all the elements available to build a consistent EU agenda.¹⁰

Linked to this, the question that keeps cropping up is whether we need a stronger health mandate and how this can be achieved. Some are suggesting a review of the EU's health strategy. Whereas the Commission argues that the strategy is still valid since the public health challenges it identified back in 2008 have not really changed, it could also be said that it is a compilation of issues to be addressed by the EU rather than a policy document setting priorities, assigning responsibilities and outlining ways of implementation and assessment. Others are calling for another revision of the Treaty to establish a more solid legal base for health action at EU level.¹¹ As appealing as it may seem to push the reset button and design a completely new legal base for public health in the EU, we should be aware of the serious risks connected to that option, especially in a climate in which the delegation of power back to the national level is openly debated to compensate for loss of competencies in other areas. Hence, any new public health article might end up being less powerful than what we have now.

Perhaps a more promising strategy would be to push for "Health in all EU policies" in order to make sure that health impact is duly considered when developing policy in other areas. In fact, the opening of Article 168 provides a clear and solid basis for this: *A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.* With health impact assessment (HIA) we already have an effective tool and a sound methodology. It's just a matter of putting this into practice. Moreover, positive health impacts should be better marketed by the EU: the smaller but important advances realised through initiatives, such as the joint purchasing of vaccines or the European reference networks established under the cross-border care directive,

could pave the way towards a real layer of European health care and even – why not? – European solidarity.

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VOICES FROM EUROPE



Alois Stöger: Federal Minister of Health, Austria



Tonio Borg: EU Commissioner for Health and Consumer Policy



Zsuzsanna Jakab: Regional Director of the WHO Regional Office for Europe



Martin McKee: Professor of European Public Health at the London School of Hygiene and Tropical Medicine



Nicola Bedlington: Executive Director of the European Patients Forum (EPF)



Richard Bergström: Director General of the European Federation of Pharmaceutical Industries and Associations (EFPIA)

In the light of the recent European election outcomes, how do you envisage the further development of the European social model and its core values?

EU Health Commissioner Tonio Borg does not see in the election result a rejection of the European project. *Despite the crisis, there is still support for a European Union that remains united and open whilst seeking to be stronger to defend our values and interests. However, the results also call for addressing the concerns of those who voted in protest, or who did not vote.* To **Professor Martin McKee** this popular discontent is due to the failure of the European institutions to respond appropriately to the economic crisis. *Especially in those countries that have been worst affected by austerity, Europe is perceived to have prioritised the interests of the banks and other financial institutions over those of the people.* According to **EPF's Executive Director Nicola Bedlington** the rise in euro-scepticism indicates that the EU must redirect its efforts towards concerns that are closer to EU citizens, like health, to add value to people's lives and renew faith in the European process. *European values of universality, access to good quality care, equity and solidarity, safety and patient involvement are unfortunately still not a reality for all patients. Disparities have been exacerbated by austerity measures.* **WHO Regional Director Zsuzsanna Jakab** also hopes that the outcome of the European elections may contribute to further promote these values. *As modern European communities are becoming more globally interactive and the health and wellbeing of its citizens is becoming dramatically linked to seemingly disparate factors, a framework for health to uphold these core values and to ensure the right to health for everyone is really needed.* **Austrian Health Minister Alois Stöger** reminds us that the Union's aim, as laid down in Article 3 of the Treaty, is to promote peace, its values and the wellbeing of its peoples. *I am deeply convinced that economic and social progress are inseparable. Tackling the emerging social challenges in a context of financial constraints and demographic pressures requires more than ever a strong European social model based on the values of social protection for all and solidarity.*

EFPIA Director-General Richard Bergström is inherently optimistic. *With a new generation of politicians in Brussels, we have an opportunity to reaffirm what Europe stands for. Europe's social model, for me, has to be at the heart of defining what the EU is about. It would be deeply ironic if our own commitment to the social model would weaken at a time when much of the world is trying to copy the degree of social protection – especially in health care – that we have pioneered.* Also **Commissioner Borg** thinks it would be hazardous to speculate about the effect of this particular election on the development of the European social model. *I believe that the values that underpin our health systems and our action at European level are widely shared and stable. Health systems form a cornerstone of the European social model and are a key component of our efforts to fight the challenges brought upon us by the economic crisis and can help addressing people's current concerns.* Yet, **Professor McKee** points to some inconsistencies. *Take the secretive nature of discussions on the Transatlantic Trade and Investment Partnership. Its provision for investor-*

state dispute mechanisms is widely viewed as a means for powerful corporate interests to undermine the European social model. There is a real danger that the wrong message is taken. What is being called for is a Europe that places the interests of its citizens first, with the major corporations—whether in the financial sector or elsewhere—at their service and not the other way round.

After the first 20 years of an EU health mandate, what do you consider as its main achievements and what vision do you have for the EU's role in health and health systems in the next 20 years?

All interlocutors agree that great progress has been made in the area of health at EU level over the last 20 years, even if only slowly. **Minister Stöger**: *If you only look at all these measures to secure the quality of food products, to protect consumers and to secure a healthy environment, we see that important areas have been harmonised.* **Commissioner Borg** continues: *The EU has established a legislative environment benefiting patients and economic operators. With the whole body of legislation on Organs, Blood, Tissues and Cells, the recent revision of the Tobacco Products Directive and of the regulatory framework on clinical trials and on pharmaceuticals we have further consolidated European health law.*

Promoting cooperation between the Member States on health policy and on health systems is seen as another important aspect of the health mandate. **Commissioner Borg**: *Guided by the EU Health Strategy and supported by the successive Health Programmes, the Commission supported health systems' efforts to address ever growing challenges by fostering cooperation and exchanging good practice across Europe on a wide range of shared concerns, ranging from addressing lifestyle factors over and tackling chronic diseases to capacity building in areas such as health technology assessment and health workforce.* **Nicola Bedlington** also sees an increasing recognition by Member States that EU collaboration is in their interest. *This has been particularly apparent in the area of patient safety and quality of care. Regrettably, we also see signs of disinvestment in patient safety in some countries due to financial constraints. This is particularly worrying as cutting health care budgets is counter-productive and will not contribute to the sustainability of health systems in the long run.* **Richard Bergström** agrees: *The well-documented health consequences of the Austerity programmes – where too many blunt instruments were used at the expense of genuine efficiency—could have perhaps been mitigated had health had a stronger voice in economic policy decisions.* **Martin McKee** notes that despite of the EU's limited competence in the field of health, the Commission does have a powerful weapon at its disposal. *So far, DG SANCO has made only limited use of its power to assess the health impact of all EU policies, including the impact of austerity.*

Commissioner Borg recognises that there is still a long way to go to establish a European Union for Health but is convinced we should use all means at our disposal to achieve this goal. *Take for instance the new Joint Procurement agreement on medical*

countermeasures which I have signed with Member States in June. Also The Cross-border Health Care Directive that entered into force last year is considered a major milestone. **Nicola Bedlington** says: *These kinds of measures can have significant scope to empower patients and, if implemented properly, they can have a transformative effect on health care that is wider than the scope of the legislation itself.* **Minister Stöger** warns however: *We have to proceed step-by-step. The patient rights directive was indeed a big step forward for the provision of cross-border health services, but now further adjustments of the existing processes are needed as well as a re-thinking of all involved partners.*

Finally, **Zsuzsanna Jakab** also points to the role of the EU in global health. *The EU tobacco regulations provide tremendous support to the Framework Convention on Tobacco Control (FCTC). The EU Decision on serious cross-border threats to health put the EU at the forefront in addressing global health emergencies and implementing International Health Regulations. The EU's work on environment and health is a source of inspiration for other parts of the world. At the same time, experiences such as the passage of the Tobacco Products Directive provide us with valuable lessons about the activities of lobbyists representing powerful corporate interests that seek to undermine health,* says **Professor McKee**. *More detailed research will call for much stronger action on transparency.*

In preparation for the next legislative period and implementing its Europe 2020 growth strategy, how will the current policy frameworks and instruments have to be used or reviewed in order for the EU to fulfil its role in promoting, protecting and restoring the health of its citizens?

For **Minister Stöger** the top priority of the next legislative period will be the recovery of the economy and the radical reduction of unemployment. *Measures have to be taken to reduce undesirable developments in the financial markets, which endanger the EU as a whole, but especially social security including national health systems.* **Martin McKee** adds: *As a modern public health physician I must also look upstream and call for reform of the flaws in Europe's financial system that created the current problems, coupled with action to redress the otherwise inexorable trend in inequality that has recently been explained elegantly by Thomas Piketty.* **Nicola Bedlington** confirms: *The EU should break down health inequalities, striving to make treatments available to everyone and encompassing the whole care continuum. We need more commitment to Health-in-All policies, particular attention to the needs of vulnerable groups and investment in key change agents.* Also, **Richard Bergström** believes it is possible to not only maintain what Europe has now, but to also address some of the glaring inequalities that persist. *But we may have to start doing things differently, forge new partnerships and challenge old silos. In a majority of EU countries my industry has entered formal agreements with governments to provide stability and predictability of*

the medicines bill, while seeking to improve access to new medicines. Such an approach to partnership could be extended to other areas.

Commissioner Borg replies: *The Commission has fulfilled its role, in full respect of the Treaty and of the subsidiarity principle. The Europe 2020 process is currently under review – in wide consultation – with new Commission proposals foreseen by early 2015. The Commission will need to listen carefully to citizens and stakeholders' views on whether or not health outcomes are sufficiently taken into consideration in our current strategy and whether more attention needs to be given to the link between access to good quality health care services and support to the EU's poverty reduction target. In this respect, Zsuzsanna Jakab points to the importance of universal health coverage (UHC). UHC is both a means for achieving good health outcomes progressively (through full coverage of health services, and across all stages of life) and a desirable end in itself (through the assurance of protection from financial risk).*

As European citizens demand more value for money in health care, what can the EU contribute to improving the performance and efficiency of Member States' health systems?

Professor McKee is rather sceptical. *The role of the EU is even more limited with respect to health care than it is in relation to health. Perhaps more importantly, there are certain things that the EU should not do. European health systems represent remarkable value for money. Yet, paradoxically, there are frequent calls for more markets in health care, based on ideas in use in the USA, the country that spends most among industrialised countries and has the worst health system performance. Commissioner Borg argues that no health system in the EU is sustainable without in-depth reforms. The EU can help optimise the way Member States' health systems work in several areas, by pooling knowledge and resources, fostering good practice exchange, providing economies of scale in terms of analysis and studies, and facilitating access to expert advice on health systems reform. This is explained in the Commission's recent Communication on "effective, accessible and resilient health systems". We have to keep fostering innovation and safety, not only to ensure high quality standards for health products and services but also to support European research excellence that benefits patients and boosts the competitiveness of industry. Ultimately, these reforms aim at ensuring that Member States are able to provide citizens with quality health care for generations to come; and as such, to preserve our European social model of health care for all.*

Minister Stöger agrees that the most important goal is to provide a sustainable financial basis for health systems. *It is no question that measures are needed, to organise health systems in the most efficient and effective manner. What we need are innovative approaches, including social and organisational innovation, to balance future demands against affordable resources. Following the thought of subsidiarity, measures should be set at the right level. Health systems vary significantly*

between Member States and will continue to do so. Best practice models are for sure helpful, but a one-size-fits-all approach would not work. There is still much to do and tuning is needed but the development goes in the right direction. Also EFPIA Director Bergström sees a lot of good progress. In general, the trend towards investing in the sort of infrastructure that allows the more effective collection, transmission and analysis of data should help health care systems make better 'value-based decisions' – not just in medicines, but throughout the system. Getting this right in Europe will attract research and development investment as well as promote good health policy decisions. Europe now needs to think long-term and be creative in seeking out solutions to what we know will be a challenging few decades.

For **Regional Director Jakab** the growing burden of non-communicable diseases (NCDs) presents an immense challenge for Member States. *Given its close linkage with social and environmental health determinants, we know that resolving this issue will require a whole-of-society, whole-of-government approach and a strong partnership across sectors, as set out in our new Health 2020 policy framework. The EU has a major role to play in addressing these issues. Nicola Bedlington adds: Chronic diseases are seen as a sustainability challenge for European health systems. This is usually presented in financial terms but it needs to be seen from a patient's perspective to ensure care is designed and delivered around patients' specific needs. Innovation in health care should focus especially on the way care is organised and delivered and how it can benefit patients. Patients, when involved from the onset, can help determine what valuable innovation is to us. As evidence shows patient empowerment and involvement is also cost-effective and leads to better health outcomes and patient satisfaction. She concludes: What is very positive is that today patients are recognised as a legitimate stakeholder group and our views are sought and increasingly reflected in EU legislation and documents.*

(*) The reflections and quotes were picked from written contributions received from the various panel members to the questions submitted to them. The statements received were organised and paraphrased by the Eurohealth editors.

VOICES FROM PARLIAMENT

Eurohealth asked a former, returning and new Member of the European Parliament (MEPs) for their reflections on the challenges and opportunities for health at EU level under the new term of the European Parliament.

Louis Ide



“Multi-resistant bacteria will have a huge impact on society in Europe and the world as a whole

For newly elected, Belgian MEP **Louis Ide** (European Conservatives and Reformists Group) promoting better quality of life and addressing inequalities in access to health care and in health outcomes are

key. Challenges include tackling poor mental health and high rates of suicide in some EU countries and

investing much more in chronic disease prevention, but without doubt he argues the highest priority should be given by the international community to combating multi-resistant bacteria for European and global society. This is a threat that Dr Ide, as a medical microbiologist & infection control specialist, has been aware of for some time.

Austrian MEP, **Karin Kadenbach** (Group of the Progressive Alliance of Socialists and Democrats in the European Parliament) has sat in the Parliament since 2009 and has served before on the EP's Environment, Public Health and Food Safety Committee. She stresses better access to

health promoting activities and the dissemination of reliable high quality information to allow citizens to make better informed choices. Her vision sees preventative medical measures further developed and promoted by the international community.

Karin Kadenbach



“Preventative measures need to be further developed and promoted by the international community

Europe will need to achieve further improvements to guarantee access to affordable medicines, while ensuring that they are safe and effective. The important contribution of the European pharmaceutical sector to economic growth, sustainable employment and wellbeing must not prejudice patient safety.

After being an MP and health minister in the UK government between 1993 and 1996 **John Bowis** spent a decade in the European Parliament where among other things he devoted much attention to issues around mental health and cross-border care. He believes that it is a time for hope and even optimism in health policy making in Europe, so long as policy makers give health the priority that it deserves. Politicians in Europe must build on its health history; understand the crucial link between health and wealth; and develop new opportunities

John Bowis



“The new ‘semester’ system at long last recognises the part good health can play in improving economic performance and the economic drag that comes from poor and untreated health problems

to transform both. He welcomes recognition by the ‘semester’ system of the importance of health and points to exciting prospects for new health benefits for citizens arising from the Cross Border Health Care Directive. It opens the way to safe transferable prescriptions, to secure transfer of health records and to reliable use of telemedicine. As efforts continue to identify cost effective solutions, gene research and the exploration and development of personalised health care and, within that, of personalised medicine, may prove to be good investments.

BUILDING **EU HEALTH POLICY** FOR THE FUTURE

By: Artur Furtado, Georgina Georgiou and Patricia Nelissen

Summary: This article explores policy-making at the EU level in the area of health, particularly the importance of partnership relationships and taking into account the global dimension of health. One crucial aspect is the way that scientific advice feeds into policy-making and how that science is effectively translated into policy practice. Moreover, the EU's contribution to the development of global health is based on promoting values, norms and regulatory models at international level in its regional, bilateral and multilateral relations. A number of key questions related to these key health policy dimensions will be explored in a session hosted by the European Commission's Directorate – General for Health and Consumers at the 2014 European Health Forum Gastein.

Keywords: EU Health Policy, EU Policy-making, Global Health, Stakeholders, Evidence-based Policy

Introduction

To be effective, modern health policy needs to involve partners across society in policy development and implementation, and has to take into account the global dimension of health. This is all the more relevant at the European Union (EU) level. In a session hosted by the European Commission's Directorate-General (DG) for Health and Consumers at the 2014 European Health Forum Gastein, a number of key questions related to these key health policy dimensions are explored.

This article focuses on certain aspects of policy-making at EU level in the area of health, mainly the way EU policy on risk factors and diseases is developed and implemented through partnerships, globally and with Member States and stakeholders. It also explores how scientific advice feeds into policy-

making at EU level, including looking at some issues related to translating science into policy practice. Finally, we look at how the EU contributes to the development of global health by promoting values, norms and regulatory models at international level in its regional, bilateral and multilateral relations.

Stakeholder involvement: not enough, just right or too much of a good thing?

While there is broad agreement that health is a matter of relevance across policies and that its promotion requires the commitment of multiple actors, there is room for discussion about the place of public policy and the right balance in the relationship between public health authorities and health stakeholders.

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Building EU health policy for the future

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Note: This article sets out the authors' personal views and should not be regarded as describing a formal position of the European Commission.

Have the public bodies been played by industry in the recent past, as some fear? Or, quite the opposite, is it the case that we need to develop partnerships with the NGOs and the for-profit sector to ensure faster policy results? Or, perhaps still, is the existing cooperation striking the right balance? In hindsight, cases of lack of regulation are not difficult to identify in the wake of the financial crisis. On the other hand, examples of poorly devised legislation are also easy to come by. How much and what type of involvement should stakeholders have in the development of public policy in the field of health? What governance structure should frame those contributions? How can we better prepare the future, in a realistic, practical approach?

“Scientific Committees: excellence, independence and transparency”

Interesting examples for this debate may be drawn from the EU action on nutrition and physical activity. It is framed by the 2007 Strategy for Europe on Nutrition, Overweight and Obesity-related Health Issues¹, that set up action-oriented partnerships involving the Member States (High Level Group for Nutrition and Physical Activity²) and civil society (EU Platform for Action on Diet, Physical Activity and Health³). Within the scope of the Platform, stakeholders have already launched more than 300 voluntary commitments. Examples range from dedicated newsletters targeting expert audiences to a food and beverage industry pledge not to advertise to children under the age of twelve; a variety of results, from basic to excellent, have been achieved. What is now the best way forward?

Policies based on science and evidence

When preparing its policy and proposals relating to consumer safety, public health and the environment, the Commission relies on independent Scientific Committees to provide it with sound scientific advice and to draw its attention to new and emerging problems. The opinions of the Scientific Committees are vital for policy-makers to ensure the highest level of health and environmental protection that European citizens expect from the EU institutions. Policy-making based on sound science is the main principle underpinning risk governance and regulation in the EU.

Since 1978, three Committees – the Scientific Committee on Consumer Safety, the Scientific Committee on Health and Environmental Risks and the Scientific Committee on Emerging and Newly Identified Health Risks – have adopted more than a thousand scientific opinions, most of which have served as a basis for regulations, contributing to a more evidence-based EU policy-making. The Scientific Committees, whose members include eminent scientists from all over the world, review and evaluate scientific data in order to assess potential risks in a wide range of areas. Recent work has focused on medical devices, such as the safety of PIP silicone breast implants and metal in hip replacements, and the health effects of electromagnetic fields.

Three basic principles govern the work of the Scientific Committees: excellence, independence and transparency. An open way of functioning is in place to continually attract the best scientists and to encourage more dialogue with stakeholders, with the aim of catalysing debate and facilitating exchange of information. At the same time, a robust set of internal mechanisms is applied to safeguard the independence of the scientific work and to prevent the risk of influence from economic, social or other non-scientific grounds. A duty of confidentiality applies to information that Committee members acquire in the course of their work.

Particular attention is given to communicating the results of the work of the Scientific Committees to ensure that their conclusions are known to both the scientific community and stakeholders. In support of this aim, the entire process of the Scientific Committees' work is accessible on a dedicated website (see http://ec.europa.eu/health/scientific_committees/index_en.htm). Moreover, several scientific opinions are translated into layman language to ensure citizens can grasp the core information of these opinions.

The need for systematic, best practice risk assessment will increase further in years to come. The EU will face new challenges, in particular the risks posed by new and emerging technologies (for example, nanotechnologies), as well as from new products and services.

Global Health – think global, act local, but what to do at the EU level?

Global health is an attractive but complex concept that, in capturing and addressing the world's health problems, has come to mean all things to all people, with the result that no single definition exists (a Google search for the term on 4 June 2014 produced 383 million hits). In 2010, the European Commission stated that global health is about worldwide improvement of health, reduction of disparities, and protection against global health threats. It went further to acknowledge that addressing global health requires coherence among internal and external policies and actions based on agreed principles. There is no doubt about the global commitment to improve global health, but how can we channel this into effective and sustained action? We are told to think globally but act locally, but where and how can the EU with its policies and instruments fit into this paradigm? And from what perspective? In its 2010 Commission Communication on Global Health⁴, the Commission considered the concept through various lenses, including development, trade, security, human rights, foreign policy, and governance.

Analysing global health with a European perspective, mindful of EU interests, values, expertise and instruments, can be approached from three different angles, as recently proposed by Kickbusch and Szabo¹: i) global health governance, referring mainly to those institutions and processes of governance which are related to an explicit health mandate, such as the World Health Organization (WHO); ii) global governance for health, referring mainly to those institutions and policies of global governance which have an impact on health such as, for example, international trade or development policies; and iii) governance for global health, referring to the governance mechanisms established to contribute to global health.

The EU is a committed supporter of global health governance and multilateralism and it looks to the WHO for global health leadership. The European Commission and the WHO have put processes in place to ensure good cooperation on a wide range of issues at country, regional and global levels. The EU, collectively with the Member States, is the third largest funder of the WHO (behind the Gates Foundation and the USA) and participates actively in WHO's governing bodies which set priorities and promote the organization's values. In its bilateral relations, the EU promotes international health laws, such as the International Health Regulations and the Framework Convention on Tobacco Control and the WHO International Code of Conduct on the Recruitment of Health Personnel.

But what else can be done? The EU, as the world's first and only regional regulator and the world's largest provider of development aid, is a key player in addressing major global health scourges, including communicable health threats, non-communicable diseases and humanitarian crises. In this context, it works with and at the WHO on global health issues.

Looking at the EU's role in global governance for health leads to the question of the policy coherence of EU positions and an examination of how other EU policy areas have direct and indirect effects on health, e.g. trade, research,

development. For example, the proposed UN Task Force on Non-communicable Diseases has at least 18 UN agencies participating. Within the European Commission, DG Health and Consumers has dialogues with 26 other Commission Services on health matters. One policy of direct relevance in this context is international trade and regulatory cooperation. Ongoing negotiations of international trade agreements have shown the interest of the global health community and the need to address concerns that have been raised about potential negative impacts on health of standards convergence and the ability of governments to regulate markets for the benefit of public health. Another example is the global problem of access to medicines which is a multi-faceted problem – inside and outside the EU – but which is addressed in a coherent way amongst a range of Commission Services.

“EU policy areas have direct and indirect effects on health”

A third angle focuses on governance for global health, by looking at the mechanisms and policies designed by health authorities, both at EU and Member States' levels, to achieve coherence between internal and external policies through global health strategies. The 2010 Commission Communication on Global Health looked at four strands of action: to establish a more democratic and coordinated global governance; to push for a collective effort to promote universal coverage and access to health services for all; to ensure better coherence between EU policies relating to health; and to improve coordination of EU research on global health and boost access in developing countries to new knowledge and treatments. In recent years, several EU Member States have developed national global health strategies. It would

be useful to review how such a strategic approach has been developing and highlight common goals and values.

The EU and its Member States, as regional actors, contribute to global health, not just in driving the global agenda or in setting global priorities, but also in delivering benefits at the local level.

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TELEMEDICINE: THE TIME TO HESITATE IS OVER!

By: Terje Peetso

Summary: Considering demographic changes in Europe and higher demand for more expensive services, telemedicine would be helpful not only because of its effectiveness for prevention, diagnosis, treatment and rehabilitation but also because of its cost-effectiveness. Telemedicine would be even more effective if interoperability is in place as this would allow effective data sharing and analysis which would further contribute to better health outcomes. Concerns regarding the effectiveness of telemedicine, as well as collection and use of health data, have to be addressed in order to make telemedicine part of mainstream healthcare.

Keywords: Telemedicine, Interoperability, Data Management, European Union

Introduction

Telemedicine is defined as “the provision of health care services, through the use of Information and Communication Technology (ICT), in situations where the health professional and the patient (or two health professionals) are not in the same location. It involves secure transmission of medical data and information, through text, sound, images or other forms needed for the prevention, diagnosis, treatment of a disease and follow-up of patients”.^[1]

In 2008, the European Commission’s Communication stated that: “*Despite the potential of telemedicine, its benefits and the technical maturity of the applications, the use of telemedicine services is still limited, and the market remains highly fragmented. Although Member States have expressed their commitment to wider deployment of telemedicine, most telemedicine initiatives are no more than one-off, small-scale projects that are not integrated into health care systems*”.^[2] Since then the importance

of telemedicine has been highlighted in many documents and initiatives – the *eHealth Action Plan 2012–2020* (published together with the Staff Working Document on the applicability of the existing EU legal framework to telemedicine services),^[3] the *European Innovation Partnership on Active and Healthy Ageing*^[4] and in the research and innovation programme *Horizon 2020 Societal challenge 1* “Health, demographic change and wellbeing”.^[5]

Today, with the prevalence of chronic diseases increasing, services becoming continuously more expensive, demand for health and social services increasing, and available resources to meet demand and expectations shrinking, telemedicine would be helpful not only because of its effectiveness for prevention, diagnosis, treatment and rehabilitation but also because of its cost-effectiveness. Studies show predominantly positive results, with a clear trend towards better results for “behavioural” endpoints, (e.g. adherence

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to medication or diet and self-efficacy) compared to results for medical outcomes (e.g. blood pressure, or mortality), quality of life, and economic outcomes (e.g. costs or hospitalisation).⁵ It is also an opportunity to develop innovative models and products that will not only provide savings and better access to care but also opportunities for a new growth sector for European health and wellbeing entrepreneurs.

“Concerns regarding use of health data have to be taken seriously

However, at the same time, the most frequently cited barrier to the implementation of telemedicine solutions globally is the perception that the cost of telemedicine is too high. Almost 70% of countries that responded to the World Health Organization (WHO) second global survey on eHealth⁶ indicated the need for more information on the cost and cost-effectiveness of telemedicine solutions, and over 50% wanted more information on the infrastructure necessary to implement telemedicine solutions. Wanting additional information on the clinical uses of telemedicine was cited by almost 60% of countries; it was one of the three most requested areas of information. European Union (EU) Member States mentioned a need for information on clinical possibilities, although a lack of knowledge of telemedicine applications was not considered to be a barrier.

There are two other barriers that the EU Member States have highlighted: i) organisational culture that is not supportive and ii) a lack of demand by health care professionals. These can be linked to the issues raised in the survey, in particular the need for information on cost-effectiveness, but it also stresses the need for organisational change – the need

to do certain things in health care systems differently; for example, giving more responsibility to patients to self-manage their diseases. Putting patients in the driving seat is also a motto of the *eHealth Action Plan 2012–2020*.

Effectively sharing information about the benefits of telemedicine

The Commission has funded many projects in the area of ICT for health and wellbeing and continues to do so through *Horizon 2020*.⁷ This includes specific projects on telemedicine such as Renewing Health (<http://www.renewinghealth.eu/>), United4Health (<http://www.united4health.eu/>) and MasterMind (<http://mastermind-project.eu/>). United4Health involves approximately 12,000 patients and utilises results and good practice from previous projects and trials, including the Renewing Health project. The services being deployed and studied target diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. The MasterMind project looks at how telemedicine can treat depression. It is worth underlining that the above mentioned projects pay particular attention to cost-effectiveness and as such meet the needs of many countries that have mentioned a lack of this data as an obstacle to implementing telemedicine. First results from the Renewing Health project are expected to be published in Autumn 2014. All of these projects pay a lot of attention to the dissemination and exploitation of results among policy makers, health care managers, patients/citizens, insurers and health care professionals.

Although, the lack of demand from patients has not been highlighted as an obstacle to implementing telemedicine, there is no doubt that it would certainly help its large-scale deployment. Patients' concerns regarding the effectiveness of such services, as well as collection and use of their health data, have to be taken seriously and addressed carefully.

First of all, it is important to stress that telemedicine is not meant to replace traditional medicine and face-to-face contact between patients/citizens and health care professionals. Key information and benefits about telemedicine need

to be thoroughly explained to patients and their carers. In particular, it allows the permanent monitoring of patients' conditions, which in turn can improve treatment outcomes, prevent unnecessary hospitalisation and consequently improves quality of life. Turning to data management, patients have to be provided with a thorough explanation on how their health data is collected, stored and analysed through the implementation of relevant legislation on data protection.

Telemedicine requires interoperability

Interoperability is required for the efficient collection and analysis of data from different technological sources. This would improve the efficiency of telemedicine not only within one region or in an entire Member State but also across borders. Lack of national and internationally adopted standards is one of the obstacles preventing the achievement of successful applications of telemedicine. Ideally, good practice would include the collection of data from different sources, facilitating use, for example, through patient electronic health records. This obstacle was also mentioned by many countries participating in the 2010 WHO survey.

In the *eHealth Action Plan 2012–2020* the Commission recognises the importance of working towards achieving interoperability within its four levels: legal, organisational, semantic and technical. The main strategic and governance body at EU level for this purpose is the eHealth Network set up by Directive 0211/24/EU.⁸

Better access, better health care

Although there have been worries that the use of information and communication technologies in health care will increase health inequalities, in fact there is a trend towards more positive views on the role of these technologies in improving access to health care services. For example, teleconsultation may help in contacting an expert in another hospital, town, region or Member State for better diagnosis and treatment. It may also help people with chronic health problems who live

in remote areas to be well monitored without the need for long-distance travel. At the same time, immediate changes in treatment plans may be introduced as a result of real-time data received from daily monitoring systems. This can help to avoid a serious deterioration in a patient's condition and the need for hospitalisation. According to the Mastermind project, the use of telemedicine to treat depression has demonstrated a number of advantages which include low threshold access to proven treatments, both brief and more extensive, which, in addition, are less expensive.

Conclusions

Introducing new approaches in any health care system is not an easy task, mainly because this affects the most precious thing that we have—our health. However, modern technologies have been successfully implemented in many areas outside health care, as well as within it. For example, tele-radiology is already part of mainstream health care and tele-consultation has become a standard

procedure for many highly qualified doctors. Modern technologies offer many good solutions, the implementation of which may sometimes need more of a change in mind-set than more data demonstrating the effectiveness of the application.

Indeed, certain issues, such as interoperability and data management, need to be fully addressed in order to achieve the best results for telemedicine. However, it is already time to start using available telemedicine solutions. The time to hesitate is over!

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Paying for performance in health care. Implications for health system performance and accountability

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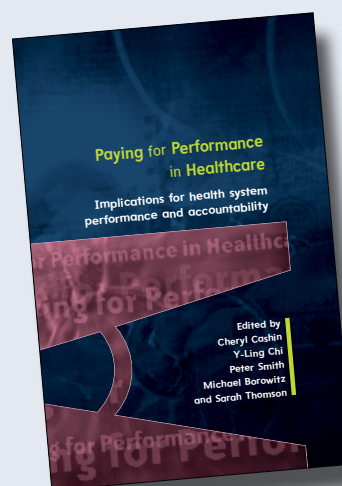
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Health spending continues to outstrip the economic growth of most member countries of the OECD. Pay for performance (P4P) has been identified as an innovative tool to improve the efficiency of health systems but evidence that it increases value for money, boosts quality or improves health outcomes is limited.

Using a set of case studies from 12 OECD countries (including Estonia, France, Germany, Turkey and the UK), this book explores whether the potential power of P4P has been over-sold, or whether the disappointing results to date are more likely to be rooted in problems of design and implementation or inadequate monitoring and evaluation.

Each case study analyses the design and implementation of decisions, including the role of stakeholders; critically assesses



objectives versus results; and examines the “net” impacts, including positive spillover effects and unintended consequences.

With experiences from both high and middle-income countries, in primary and acute care settings, and both national and pilot programmes, these studies provide health finance policy-makers in diverse settings with a nuanced assessment of P4P programmes and their

potential impact on the performance of health systems.

Contents: i) An overview of health provider P4P in OECD countries – Health provider P4P and strategic health purchasing; P4P programme design; Strengthening health system governance through P4P implementation; Evaluating P4P programmes; Lessons from the case study P4P programmes; ii) Case studies of P4P programmes in OECD countries.

IN HEALTH, EUROPE MUST BE IN THE BUSINESS OF CHANGE AND MEAN BUSINESS

By: Tamsin Rose

Summary: The big challenges for health are clear: the need for a major paradigm shift by transforming health care institutions from sickness treating systems to promoters of wellbeing. We need to get better health outcomes for less resource. Health needs to be a central part of all policy-making and an explicit outcome of government action. Consumption patterns and behaviour need to change radically to reduce the burden of chronic disease. Brussels-based think tank, Friends of Europe, sees the new European Commission mandate (2014–2020) as an opportunity and convened health stakeholders to develop recommendations for a new, improved EU approach to health.

Keywords: Strategy, Health Policy, Change, Leadership

Introduction

During the summer of 2014, there was intense political horse-trading behind closed doors between the new European Commission President and national capitals on the allocation of portfolios. Before the new Commission College takes office, now is a good moment to reflect on what a strongly committed European Union (EU) Health Commissioner could achieve for health in Europe.

Friends of Europe, a Brussels based think tank, convened a Health Working Group and brought together a diverse group of stakeholders from across Europe representing policy-makers at EU and national level, international organisations, academia, health-related industries and non-governmental organisations. The Working Group sought to define coherent messages from the health community to the new Parliament and Commission on

how they could support positive change for health in Europe. The Group met four times throughout 2013 and 2014 under the Chatham House rules which ensured a frank exchange of views and allowed some out-of-the-box thinking. The consistent theme that emerged was that the EU could be the catalyst for some of the major transformation that is needed for public health and health care but change needs to be an explicit EU goal for health. Another red thread through the discussions was the need to focus on prevention both in terms of serious political commitment and financial resources.

Strengths and weakness of health in Europe

Health is a significant asset for Europe. The universal access health care systems that exist in all EU countries are a unique feature of the region. Life expectancy

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Friends of Europe – Les amis de l'Europe – is a leading think-tank that aims to stimulate thinking on key global and European political challenges. It promotes the confrontation of ideas that is vital to policymaking and encourage wider involvement in Europe's future.

www.friendsofeurope.org



has steadily risen as living and working conditions have improved and most citizens can expect to enjoy long periods of good health, accessing care when they need it.¹ Europe hosts a thriving life sciences industry with world leading companies that are producing new drugs, medical devices and diagnostic tools. There is a well-educated workforce readily available and funding for health research has been ring-fenced, contributing to the growing body of scientific knowledge. The diversity of health care systems across Europe presents opportunities for shared learning and exchanges of experiences. EU level data collection gives insight into the operational efficiency of different health systems and allows benchmarking and realistic target setting. The EU could and should capitalise more on its health assets to achieve better health outcomes.²

“non-communicable disease burden consumes up to 80% of all health care costs

With all good news, there tends to be bad news. The societal challenges ahead are well understood – demographic change has profound implications for health and social care costs, chronic diseases consume most health care resources but are largely preventable. Health care systems are still heavily invested in expensive hospital-based curative services which deliver acute care, but are not adapted to provide patient-centric care in community settings. The poaching of health care staff from one health system to another contributes to brain drain and both shortages of skilled health care workers and skills mismatches across Europe. Chronic diseases are interrelated, are largely preventable and have common risk factors – tobacco use, poor nutrition, physical inactivity, alcohol consumption, and environmental factors. Among the six World Health Organization (WHO) regions in the world, Europe is the most affected by non

communicable or chronic diseases. It has the highest smoking rates in the world for both men (38%) and women (19%). Europeans drink more alcohol (12.5 litres of pure alcohol per year) than in any other part of the world – almost double the global average. Only North America has a higher proportion of obese citizens (26%) than the European region (22%) where more than 50% of men and women are overweight. In terms of physical activity, 35% of the people in Europe are insufficiently physically active. So Europe scores highly on all the key risk factors for chronic diseases. Unsurprisingly the resulting non-communicable disease burden consumes up to 80% of all health care costs in Europe.³

Can the EU be an agent of change for health?

Change is not easy to achieve and there are formidable barriers: the complexity of health and care systems, strong vested interests and power imbalances in the system, information asymmetries between users and providers of care, silo thinking within health care, short term crisis management rather than long term strategic planning and legacy health care institutions that are out of date and unsuitable for modern care models. The health care sector has also been slow to adopt new technology and therefore has not achieved the efficiency gains and productivity increases that other sectors have benefitted from. Change takes a long time in health care; new approaches often take ten to fifteen years to become enshrined in clinical guidelines and ineffective treatment is hard to amend or eradicate. Entrenched attitudes by health care professionals protecting their own interests often block attempts to open up areas of care for other types of skills and qualifications. The policy environment can also be slow to respond when the evidence for change is strong – it took three decades for politicians to act on the link between smoking and cancer. Despite the terrible toll that alcohol takes on society and the WHO guidance that raising the minimum price is an effective way of reducing consumption,⁴ only Scotland has attempted to regulate this and has faced strong opposition from drinks companies and other governments under EU internal market rules. There are

significant health inequalities in Europe which reflect broader inequities in society but are exacerbated by prejudiced attitudes and poor quality care within health care services. The 2013 European Commission report on Corruption in Healthcare identified problems in some EU countries with fraud and informal payments, etc. all of which undermine the efficiency of the health care system and make it hard to reform.⁵

The economic crisis has heightened the sense of urgency and sharpened the focus on reform of health systems. The dramatic drops in Gross Domestic Product (GDP) experienced by many countries post 2008 has led to deep cuts in public spending, including health and social services.⁶ The new economic governance framework gives the EU, and particularly the Directorate-General for Economic and Financial Affairs (DG ECFIN), an unprecedented right to critique national investment and spending plans.⁷ In the past, Member States have fiercely defended their exclusive right to manage health care systems and therefore have been reluctant to actively engage at EU level on broader health issues. This, in turn, led to health being a low profile portfolio within the European Commission, and the Directorate-General for Health and Consumers (DG SANCO) faces many obstacles to being seen as a major player in policy discussions.

Raising the profile of the EU Health Commissioner

For health to get a seat at the European Commission tables where the big picture of public financing and health care spending is being discussed, it needs to have a strong figurehead within the European Commission. The ideal candidate would be someone who has credibility, having served as a Minister of Health, and with experience of negotiating with Finance Ministries and other departments. If they have seniority within the Commission, for example a Vice President post, they would be in a good position to convene groups of Commissioners where health is the linking theme; for example, consumption/production patterns, consumer behaviours and climate change. To really deliver on the disease prevention agenda, the

European Commissioner for Health needs to take on some big battles. There are powerful industries that have shaped the environment for consumers, influencing behavioural decisions on smoking, drinking alcohol or soft drinks and eating patterns. They have an economic interest in maintaining the status quo and their business models would be threatened by significant shifts in these consumption patterns that are essential to boost disease prevention. Other parts of the Commission responsible for trade, the internal market, industry policy, etc. act as champions for these interests and have in the past undermined efforts to regulate on the basis of public health. The Commissioner for Health would need to get fellow Commissioners to buy into the vision of health as the key outcome of EU actions, bringing them alongside when the external lobby pressures to block change start to mount.

There are some useful policy developments that would assist the Health Commissioner in making the case for change. The utility of GDP as a measure of societal progress is being questioned. The Organisation for Economic Cooperation and Development (OECD) is developing the *Better Life Index*, which is a more nuanced basket of eleven criteria to measure performance – ranging from income and housing to health and work-life balance.¹ The incoming Commission President has promised to invest more in social Europe, marking a shift from the economic growth driven austerity measures. Given the close linkages between poverty, social exclusion, unemployment and health, this is an important development. Poor health and chronic illness can be both a driver of unemployment and a result of being out of the labour market. Health should rightfully claim a central space in future social Europe initiatives. Health is also increasingly acknowledged as being at the nexus of climate change, as a contributor to the problem (the sector uses resources intensively and produces high levels of waste) and a consequence of global warming as extreme weather events affect health and shifting climate patterns bring new disease patterns to Europe. Climate change will continue to be a headline

policy priority at EU and global level and health should be a central part of the debate on how to address it.

Stakeholders' recommendations for EU action on health

Reflecting on these challenges and opportunities, a new report from the 'Friends of Europe' think tank (due to be published shortly) distils the thinking of their Health Working Group's into a list of 23 recommendations on what the EU should 'Start', 'Stop' or 'Do Differently' during the next mandate. This approach was designed to make sure that the report did not create an unfeasible list of new tasks for the over-stretched European Commission staff to take on. The 'Start' recommendations set out some positive steps that the EU could take to reinforce efforts to effect positive change for health. The recommendations on what the EU should 'Stop doing' reflects a certain frustration with the prior lack of coordination and inconsistent follow up of initiatives. The 'Do Differently' recommendations outline how the EU could use greater focus and simplification with more joined up thinking across policy areas to end silo working.

The Working Group was undaunted by the size of the challenges facing health in Europe and felt that the timing is right for a more proactive Commissioner for Health who would find allies in the Parliament and among Health Ministers that want Europe to be a friend to health systems. If stakeholders get a clear message at the beginning of the mandate that Europe is in the business of change for health – and it means business – they will find ways to align their strategies and activities to this agenda. This might be the trigger that is needed for the paradigm shift for health.

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WHAT IS THE EU'S CONTRIBUTION TO HEALTH SYSTEM PERFORMANCE?

By: Matthias Wismar, Scott L Greer and Nick Fahy

Summary: Countries throughout Europe are striving to improve the performance of their health systems, and their impact on public finances is increasingly important. The European Union is playing a stronger role than hitherto in this area, with specific recommendations to countries on reforming health systems, and investment into health systems available from European funds, alongside its broadly positive but fragmented impact on health as a whole. As Europe emerges from the financial crisis and the strategic agenda of the Juncker Commission is developed, understanding the potential impact and contribution of Europe to health is more important than ever.

Keywords: Health Policy, Public Finances, Financial Crisis, European Union

The policy context

All countries in Europe are striving to improve the performance of their health systems. Policy-makers are aiming at better returns from time, effort and monies invested in health systems. They are also seeking to eliminate or reduce the waste in health systems caused, for example, by over- and mal-treatment or the use of ineffective or overly expensive procedures and products. Needless to say, that in times of austerity many countries are confronted with growing health demands and dwindling public budgets, putting extra pressures on them to get more value for money.

It is easy to postulate the quest for efficiency, but it is harder to define and agree on desired outcomes vis-à-vis the investment. The Council of Ministers has provided some orientation as it established specific health systems values in 2006

that can serve as goals for performance. The Council emphasised the “overarching values of universality, access to good quality care, equity, and solidarity” and “operating principles” of quality, safety, evidence and ethics, patient involvement, redress, and privacy and confidentiality. In other words, health system performance would be assessed against the ability to serve the whole population, to extend life expectancy and improve health-related quality of life, to do so regardless of social status and to distribute the burden of health care funding in a fair manner. These Council conclusions have no binding character. They were developed in the context of a wider debate on cross-border patient mobility in which Ministers of Health were eager to clarify that health systems objectives are separate from other sectors’ policies and objectives.¹

► #EHFG2014 Forum 6: Health System Performance

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Efficiency and health system performance increasingly play an important role for the European Commission. In 2010 the EU started to send Member States country-specific recommendations (CSR). These CSRs are part of the European Semester, a form of fiscal governance, designed to contribute to fiscal discipline and economic recovery in a crisis-ridden Europe. The recommendations made on health systems focus largely on financial sustainability and are pushing for structural reforms to improve efficiency. Within the Commission, the Directorate-General for Economic and Financial Affairs (ECFIN) is leading the development of the CSRs, but the conceptual basis of the assessment is not entirely clear. Recently, as mandated by the Social Protection Committee, the Directorate-General for Employment, Social Affairs and Inclusion (EMPL) has started developing a Joint Assessment Framework for health systems in the context of the Open Method of Coordination (OMC) but also with relevance to the CSR. This framework focuses on access, quality, efficiency and contextual factors, including equity-related factors,² and is therefore not so dissimilar from the values and principles suggested by the Council of Ministers.

In the context of the social investment package designed to contribute to economic recovery in Europe, the Commission is also aiming to address the needs of health systems. It is making the case for investment in health and pointing at various areas where Member States can improve the efficiency of health systems. Among the suggestions are many examples for raising health systems performance: “using financial incentives to encourage patients to register with a general practitioner (GP) or family doctor, [...] introducing activity- and/or quality-based payment for diagnosis-related groups, [...] ensuring a more balanced mix of staff skills, [...] reducing unnecessary use of specialists and hospital care, [...] better health promotion and disease prevention in and outside the health sector, [...] improving data collection, [...] using health technology assessment more systematically, [...] and] the use of less expensive equivalent (generic) drugs”.³

What is the European Union's contribution to health systems performance?

The EU is not just making recommendations on how to improve health system performance. The EU has in some policy areas exclusive or shared competencies allowing for legislating and adopting legally binding acts. It is therefore shaping—or helping to shape—policies that impact on health and health systems and their performance. And this impact is bigger than one may think. There are several health-related articles in the Treaty on the Functioning of the EU (art. 168 public health, art. 169 consumer protection, art. 191 environment, art. 153 working environment). These articles provides the legal mandate for Community action on tobacco, alcohol, environmental determinants, climate changes, diet, nutrition and physical activity, health and safety in the workplace, consumer protection and communicable diseases. It also includes information, comparison and benchmarking and actions on substances of human origin. The intensity and instruments chosen to tackle these areas vary greatly, but the actions are very relevant with regards to unburdening health systems from diseases amenable to prevention and health promotion – one way to strengthen health system performance.⁴

The EU is helping to shape policies that impact on health

A more indirect but often more substantial impact on health system performance is caused by the internal market, the coordination of social security systems, and fiscal governance. The so-called four freedoms – the free movement of goods, services, people and capital within the EU's internal market – is also the free movement of pharmaceuticals, medical devices, diagnosis and therapy and patients.

This includes a plethora of specific issues like procurement, competition law, cross-border collaboration, European reference networks, e-health, European prescription, just to name a few, which have, undoubtedly, an impact on health system performance.

The EU has various instruments to implement these policies, programmes and actions.

Directives: The Directives on the recognition of professional qualifications (health professional mobility), the Directive on patient rights in cross-border health care and the tobacco products Directive are examples of key legislation with major impact on health and health systems.

Agencies: There are plenty of agencies working in health-related fields: the European Centre for Disease Prevention and Control (ECDC), the European Food Safety Authority (EFSA), the European Medicines Agency (EMA), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the European Environment Agency (EEA) and the European Agency for Safety and Health at Work. (With a slightly different legal status, there is also the Consumers, Health and Food Executive Agency (CHAFAE).

Joint action (JA): JAs are a way of collaboration between Member States, their competent authorities and the Commission. Examples under the health programme are the JA on Health Inequalities,⁵ JA on Health Workforce Planning and Forecasting⁶ and the JA on Comprehensive Cancer Control.⁷

Budgets: There is the health programme budget, although this is rather seed money in comparison with the more substantial budgets of the Cohesion policy. In addition, the health-related funds of the *Horizon 2020* research programme contribute to health.

Fiscal governance: The European Semester, an annual review cycle, holds together a host of surveillance, assessment, benchmarking and recommendation

mechanisms based in a consciously expanding base on economic policies aimed at controlling public budgets.

Clearly, the EU has the mandate and instruments to impact on health and health system performance. But is there really sufficient policy consistency and is it focusing on the key issues?

“The fragmented nature of EU action on health makes it difficult to gain an overall picture

Electing health – electing performance?

With the recent European Parliament elections, fundamental discussions on the future direction of European Integration entered the political centre stage sometimes resulting in strictly opposing positions. Big themes like peace, economic growth, sovereignty and democracy were brought forward in the debate. These are certainly key themes; however, if we want to do justice to health systems and their specific goals, if we are to ask what benefits health systems performance, we would look at the EU and health from a more functional, if not technocratic angle: what can the EU add that Member States have difficulties to achieve by themselves?

Reviewing past contributions, the EU has clearly helped to improve health by addressing environmental determinants; European citizens are amongst the best protected in the world in terms of exposure to chemicals or pollution, for example. The EU has made progress in addressing key social determinants, such as health and safety at work, but the impact of wider social inequalities on health remains. This cannot be blamed on a lack of legal powers to act (unlike health, the social powers in

the Treaty are wide-ranging), but rather on a clear preference by national governments to address social issues domestically, rather than at European level, and likewise to keep the overwhelming weight of financial tools under national control. The EU has also made some progress in addressing the behavioural determinants of health, but most strongly for smoking. For diet and exercise or the particularly European issue of alcohol, European action has been broadly limited to providing information and leaving choices to individuals.

This broadly positive impact is not widely understood, though. The fragmented nature of the EU's action on health – being taken across a wide range of legal bases, many of which do not have health as an objective – makes it difficult to gain an overall picture. This consequently makes it difficult for health stakeholders to be part of shaping the EU's health-related discussions, when so much of the discussion and decision-making takes place in forums which are not primarily focused on health. The qualitative nature of much European health cooperation – building networks, providing comparable data for benchmarking, sharing good practice – has done a great deal to improve health, too, but works in ways that are hard to quantify and demonstrate. Often, EU activity based on internal market, competition, or trade law has received the attention – justly, as in the cases of EU action on trade in essential medicines or cross-border patient mobility.

Meanwhile, the development of EU fiscal governance is potentially important but it is difficult to say how much, or what, it will mean for health services. In response to the fiscal crises of various EU Member States after 2008, the EU strengthened its existing fiscal governance regime in order to more effectively monitor Member States' fiscal policies, economic situation, and policies that might in the future lead to imbalances. Given the public expenditure of health systems, it is no surprise that fiscal governance mechanisms start to make recommendations about health system reform. It remains to be seen how effective the fiscal governance system, notably the European Semester, is at

changing health policies or stabilising economies for growth, but it is worth following.

It is therefore overdue to have an informed debate on the achievements and prospects of the EU in health and health systems and on the appropriate areas of, and instruments for, action. Only if we are prepared to asked these questions on the linkages between EU and health can we make informed decisions on electing health and improving health system performance at European and Member State level.

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FROM MILLENNIUM DEVELOPMENT GOALS TO THE **POST 2015 DEVELOPMENT AGENDA**

By: Nedret Emiroglu and Evis Kasapi

Summary: It is crucial to accelerate efforts along the last mile of the race to meet the Millennium Development Goals (MDGs) in order to achieve the goals in the areas where progress is lagging behind. The unfinished agenda of the MDGs, noncommunicable diseases, sexual and reproductive health and rights and Universal Health Coverage, should be addressed in the post-2015 development agenda, through a holistic and inclusive approach, based on the concept of well-being and not merely the absence of death and disease. Health 2020: the European policy for health and well-being will set the ground for implementing this new vision in the region.

Keywords: Millennium Development Goals, World Health Organization, UN, Post 2015 Development Agenda, Health 2020, Health Inequalities

Introduction

“Better health for Europe” across the 53 countries in the World Health Organization’s (WHO) European Region is the common priority for WHO and its Member States, and collective efforts are needed in order to sustain the health gains that have been made so far, and to ensure the highest attainable standard of health, as one of the fundamental rights of every human being across countries and populations.

Across Europe and Central Asia, health has greatly improved in recent decades and countries have made significant advances towards the Millennium Development Goals (MDGs).¹ However, areas remain in which action has stagnated and health inequities persist between and within countries in the region. For example, there is a sixteen year gap between the lowest and highest life expectancy rates at birth

and there are marked gender differences. Ethnic minorities, some migrant communities and groups of travellers, such as the Roma, continue to suffer disproportionately from preventable and treatable diseases.

The “unfinished business” of the MDGs, the rapid growth of non-communicable diseases (NCDs), disabilities and mental health disorders, environmental health risks, and the need to improve public health capacities and strengthen health systems under financial constraint, all call for a new approach to health in the 21st century. Many of the initiatives designed to propel the post-2015 development agenda focus on these challenges. The Global Thematic Consultation on Health,² one of a series of consultations convened by the United Nations to inform the new development agenda, called for new goals, which, building on the existing

► **#EHFG2014 Forum 7:**
From MDGs to the post –
2015 agenda

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health-related MDGs, set more ambitious targets and focus on sustainable health and well-being for all. The Regional Consultation, *Inclusive and Sustainable Development: Perspectives from Europe and Central Asia on the Post-2015 Development Agenda*,¹ that took place in Istanbul, Turkey, on 7–8 November 2013, highlighted that: “Any goal on health should advocate for a whole-of-government, whole-of-society and a life-course approach, crucial for addressing the social, economic and environmental determinants of health and for the well-being of societies at large”. The unfinished agenda of the MDGs, universal health coverage, NCDs and sexual and reproductive health and rights should be addressed in the future development framework. Finally, *Health 2020: the European policy for health and well-being*,² endorsed by the WHO Regional Committee for Europe in 2012, provides a framework for action across government and society and will set the ground for implementing this new vision.

Uneven progress in achieving health-related MDGs

Substantial progress has been made in reducing child and maternal mortality, and morbidity and mortality due to HIV infection, tuberculosis (TB) and malaria. Progress in many countries with the highest rates of mortality has accelerated in recent years; nevertheless, large gaps persist among and within countries.³ The current trends form a good basis for intensified collective action and expansion of successful approaches to overcome the challenges posed, and to achieve the MDGs.

Child and maternal health

There has been a steady decline in both under-five and infant mortality rates across the Region – however, with stark inequities between countries and within countries. The regional average of the under-five mortality rate decreased from 34 per 1,000 live births in 1990 to 14 in 2010. This corresponds to a reduction of almost two-thirds, and is very close to the 2015 target of 11 deaths per 1,000 live births. Regional average infant mortality rates also have declined, from 28 per 1,000 live births in 1990 to 12 in 2009.^{4 5 6}

“NCDs account for the largest proportion of mortality

The European regional average maternal mortality decreased from 44 per 100,000 live births in 1990 to 20 in 2010.⁷ Despite the progress, the European regional average mortality decline of 3.8% is short of the 5.5% needed to reach the MDG target 5A. In Central Asia and Caucasus the annual decline is even less (2.1%). In addition, there are big discrepancies between and within countries, with rates ranging from more than 75% above to more than 60% below the regional average.

HIV/AIDS

HIV remains a serious public health challenge in the region. Newly reported cases of HIV continue to increase in the region, while globally, the number of people newly infected with HIV is decreasing. The total cumulative number of people (ever) diagnosed and reported in Europe is over 1.5 million, including 131,000 new HIV cases in 2012.⁸ The gains in HIV treatment are unevenly distributed. In the east, antiretroviral therapy (ART) coverage remains low, with relatively few people who are eligible actually starting ART (35%) and achieving viral suppression. As a result, the number of AIDS cases and deaths due to AIDS are increasing. In the west, where ART coverage is high, the numbers of cases and deaths are decreasing.

The HIV epidemic in the WHO European Region is concentrated in socially marginalised populations: people who inject drugs and their sexual partners, men who have sex with men, sex workers, prisoners and migrants. Strategic information about the epidemic has become increasingly available and of higher quality. However, even though an increasing number of countries are adopting evidence-informed policies for preventing HIV among key populations, implementing harm reduction interventions and programmes targeting

prevention of sexual transmission in national AIDS plans remains a challenge for many.

Tuberculosis

TB is still a major public health problem in the WHO European Region with an estimated 350,000 new cases and more than 35,000 deaths occurring every year,⁹ of which more than 80% are in Eastern Europe. The major burden in the region is constituted by eighteen high-priority countries with 85% of TB cases and more than 99% of all multi-drug resistant (MDR)-TB cases. The burden varies between and within the countries, from a range of less than one TB case per 100,000 population to about 160 TB cases per 100,000. There are also large differences in TB rates within the countries, including in Western Europe, where TB rates can vary up to several times higher in some districts of capital cities compared to other districts.

In the last decade, TB incidence has been falling at an average rate of 5% per year, which is the fastest decline among WHO regions. In 2012, the estimated TB prevalence was 56.4 per 100,000 population, with an average decline rate of 7.7% during the last decade. If the downward trends continue, it seems feasible that the MDG 6 target of a 50% reduction in incidence and prevalence by 2015, against the baseline of 1990, will be reached. However, with regard to mortality, the current modest decline – an estimated 36,000 deaths due to TB, equal to 3.9 deaths per 100,000 population reported in 2012 – suggests that the target for halving mortality will not be achieved in the region.

The WHO European Region has the highest MDR-TB rate in the world, with fifteen European Member States in the top list of 27 high MDR-TB burden countries globally. The prevalence of MDR-TB among new and previously-treated cases amounted to 16% and 45% respectively. Treatment coverage for MDR-TB patients has increased from 63% in 2011 to 96% in 2013; however, the treatment success rate for MDR-TB patients is 48.5%, far below the target of 75%.

Growing burden of NCDs and mental health

Today, NCDs account for the largest proportion of mortality in the WHO European Region, accounting for about 80% of deaths in 2008. Three main disease groups (cardiovascular diseases, cancer and mental health disorders) cause more than half the burden of disease (measured using disability-adjusted life-years – DALYs).

The determinants of these conditions are complex and involve both individual and societal factors. Individual variation in susceptibility and resilience is in part genetically determined, while the social determinants – the circumstances in which people are born, grow, live, work and age – are largely influenced by inequities in the distribution of power, money and other resources. In particular, socioeconomic status in early life greatly influences later susceptibility and experience of disease.

The economic impact of these conditions threatens to overwhelm health systems in many countries in the region. For example, cardiovascular diseases cost the European Union (EU) economies an estimated €192 billion per year.¹⁴ There are growing costs to the health care system, but also broader effects: absenteeism at work, decreased productivity and increased employee turnover. Individuals and their families face reduced income, early retirement, increased reliance on welfare support and a burden of direct and indirect health care costs, while the state faces huge losses in taxes from both lack of employment and reduced consumer spending.

Public health capacities and health systems under financial constraint

Strengthening health systems is key to improving population health – it is an investment in a healthy workforce, economic growth and human and social development. The requirement, particularly at times of economic downturn, is for a needs-driven health system that improves health outcomes, and the protection of access and services for low-income and other vulnerable people. Universal access provides a benchmark for this.

Universal Health Coverage (UHC) and access, suggested as the key contribution by the health sector to achieving health goals and targets and to improving population health more broadly, combines access to health services (promotion, prevention, treatment and rehabilitation), the living conditions needed to achieve good health and financial protection to prevent ill health from leading to poverty. Few countries reach the ideal, but all – rich and poor – can make progress.

“
Strengthening
health systems
is key

Across the region skills and infrastructure are patchy. Coordination between public health and health and social care services is often poor and financial policies and incentives are not conducive to effective coordination of care. There is variation in clinical practice and a lack of evidence-informed pathways for the whole continuum of care. Priority and expenditure continue to favour acute curative services and high-technology diagnostics.

Furthermore, many people experience out-of-pocket health expenditure that places a catastrophic burden on their household budgets, raising severe barriers to accessing care. This situation has worsened during the economic downturn. There is now good evidence that long-term unemployment is associated with higher levels of disease, especially mental health problems, and increased mortality from suicide, especially among the poor and vulnerable.⁵

Faced with these challenges, across the WHO European Region, much remains to be done. There are powerful arguments for “going upstream” to address the root causes of ill health, yet investment in health promotion and disease prevention remains weak. Establishing coherent interdisciplinary health care teams with effective management is a priority.

National and subnational health policies, strategies and plans are vital to ensure a comprehensive and structured approach to long-term planning and priority setting. Health policies must become more evidence informed, intersectoral and participatory, and leadership transformed accordingly.

A development agenda focused on health and well-being, and equity

The MDG agenda is an unfinished business in the region. It is crucial to accelerate efforts along the last mile of the race in order to achieve the MDGs in the areas where progress is lagging behind, and which remain critically important today. The unfinished agenda of the MDGs, universal health coverage, NCDs and sexual and reproductive health and rights should be addressed in the future development framework.

The Global Thematic Consultation on Health concluded that an overarching goal for the wider post-2015 agenda should recognise health as a critical contributor to, and outcome of, sustainable development. It should call for a holistic and inclusive approach, based on the concept of well-being and not merely the absence of death and disease. The Consultation aimed at maximising healthy life expectancy, with the UHC being a key instrument in this respect. The Regional Consultation *Inclusive and Sustainable Development: Perspectives from Europe and Central Asia on the Post-2015 Development Agenda*, echoed the necessity of taking a holistic approach and tackling the social, economic and environmental determinants of health.

Moving towards UHC requires strong efficient health systems that can respond to the full range of health determinants and deliver quality services on a broad range of country health priorities. Health financing systems are required that can raise sufficient funds for health, and also provide access to essential medicines and other supplies and equipment, good governance and health information, and a well-trained and motivated workforce.

Setting the ground for the new development agenda, *Health 2020*, through its strategic objectives aims to:

- improve health for all and reduce health inequalities; and
- improve leadership and participatory governance for health.

Combating health inequalities and achieving the best possible health and well-being for all requires a range of policy and governance interventions, mainly in the following areas:

- Addressing the social, economic and environmental determinants of health through intersectoral action and integrated policy measures;
- Tackling environmental threats to human health, including those related to air quality, climate change, transport and water and sanitation. In this regard, the European Environment and Health Process is critical to shaping appropriate policies and actions in the region;
- Taking a life-course approach to increased equity in health, beginning early in life (with pregnancy and early childhood development) and continuing with school, the transition to reproductive age, working life, employment and working conditions, and circumstances affecting older people;
- Intervening to prevent the transmission of disadvantage and health inequity across generations;
- Putting in place policies that remove gender differences in health and social and economic opportunities;
- Strengthening national health information systems, civil registration and vital statistics, down to the district level and below, as prerequisite for measuring and improving equity.

Building the governance required to orchestrate a coherent response across government and society which results in better health outcomes remains one of the greatest challenges in global health. Addressing the priorities put forward by *Health 2020: the European policy for health and well-being* provides a framework for action across government

and society and calls for a combination of governance approaches that promote health, equity and well-being.

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LEADERSHIP IN PUBLIC HEALTH: REDUCING INEQUALITIES AND IMPROVING HEALTH

By: Katarzyna Czabanowska

Summary: There is a developing consensus that public health organisations should engage in building leadership capacity. To develop effective public health leadership therefore requires these organisations to actively engage in developing more leaders at every level. This article aims to stimulate debate on the kind of public health leadership needed today to reduce inequalities and improve health and well-being. Definitions and a new model of public health leadership are discussed, and its meaning is further explored via the results of interviews with European public health leaders. Some new developments in transformational public health leadership training and capacity building initiatives are highlighted.

Keywords: *Public Health Leadership, Continuous Professional Development, Public Health Capacity, Europe*

Introduction

Although leadership is a well-known concept within organisational science, public health leadership has still not been well-defined. There is a developing consensus that public health organisations should engage in building leadership capacity. To develop effective public health leadership therefore requires these organisations to actively engage in developing more leaders at every level.

A key driver in improving leadership within public health is that the nature of the challenges faced by such professionals is evolving. The combination of a range of socioeconomic drivers, including ageing populations and workforces, globalisation,

consumerism and individualism all have an effect on health and health-related issues leading to increasing health inequalities. In addition, modern global developments include: over consumption, increasing social inequalities and rising rates of mental distress and disorder. In Europe, these challenges are currently exacerbated by the impact of global recession and austerity measures that have been introduced in many European countries, which are putting health systems under significant financial pressures and forcing them to deliver more with diminishing resources. Therefore, developing effective leadership is essential.

► #EHFG2014 Forum 1: Public health leadership

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What is public health leadership?

Definitions of public health leadership vary from the idea that it includes commitment to the community and the values it stands ⁹ for to the argument that public health leaders differ from leaders in other sectors as they are required to balance corporate legitimacy, whilst also existing outside the corporate environment. ² A more collaborative world will require a new generation of leaders in public health with new mind-sets, an appetite for innovation and interdisciplinary collaboration and a strong dose of political savvy. ² A public health leader “must be the transcendent, collaborative ‘servant leader’ who knits and aligns disparate voices together behind a common mission.” ²

“make
decisions in an
increasingly
complex
environment

Public health leaders need to be exceptional networker-connectors, capable of putting the pieces of the puzzle together; they must combine administrative excellence with a strong sense of professional welfare and actively develop the profession, articulate its shared values, and build for the future. ² Today, the particular type of leadership required is not of a traditional command and control variety but rather akin to what has been termed adaptive leadership: leading in contexts where there is considerable uncertainty and ambiguity, and where there is often imperfect evidence and an absence of agreement about both the precise nature of the problem and the solutions to it. ² Professional development of public health leaders requires competency-based instruction to help them develop the abilities to address the complex and evolving demands of health care systems.

Public health leadership competency framework

Whilst considerable work has been done in the development of leadership competencies in the field of health worldwide, these frameworks seem very generic and none have been specifically developed to support the educational curriculum for public health professionals. A new model has been developed within the framework of the *Leaders for European Public Health Erasmus Multilateral Curriculum Development Project* (LEPHIE), supported by the EU Lifelong Learning Programme. Based on a review of public health and public health leadership competency frameworks, leadership literature and expert review panels, the framework was developed to support the continuing professional development (CPD) curriculum and facilitate self-assessment of public health leadership competencies.

Competencies are composites of individual attributes (i.e. knowledge, skills, and attitudinal or personal aspects) that represent context-bound productivity. ²

Fifty-two competencies are distributed around nine domain areas, including: Systems Thinking, Political Leadership, Building & Leading Interdisciplinary Teams, Leadership and Communication, Leading Change, Emotional Intelligence & Leadership in Team-based Organisations, Leadership Organisational Learning & Development, Ethics and Professionalism. ² The Public Health Leadership Competency Framework can serve as a useful tool in identifying gaps in knowledge and skills and shaping adequate competency-based CPD curricula for public health professionals. It is also an attempt to define, profile and position public health leadership through a systematically developed, comprehensive and multidisciplinary competency framework which can be used by public health professionals as a tool for self-assessment and personal development planning. ²

Leadership in the contemporary public health context

The results of a recent survey carried out by the Association of Schools of Public Health in the European Region (ASPHER) reveal that it is still not

common for leadership development to be included in European public health training programmes. ² At the same time, *The Lancet* Commission raised the question of how higher education institutions delivering public health education can provide the content and context to initiate a major reconsideration of working and learning patterns which incorporate novel forms, based on the principles of inter-professional collaboration. ¹⁰ In response to this need, a model representing the meaning of contemporary public health leadership in a European context was developed based on in-depth interviews with prominent European public health leaders ¹¹ within the LEPHIE Project.

Box 1: Six themes shaping public health leadership

- European public health context
- Inner path of leadership
- Essence of leadership
- Emerging styles of leadership
- Future leader's imperatives
- Benefiting society and improving wellbeing

Source: Reference ¹¹

The interviews were conducted to develop an understanding of the nature of public health and identify skills needed by public health leaders to successfully meet present and future patient and population health requirements as well as help tackle health inequalities. The model consists of six themes identified from the interview data (see Box 1). This model does not reflect a particular leadership theory or orientation but presents a picture of current public health leadership based on the real life experiences of public health leaders. However, elements of it resonate with aspects of generic theories such as transformational leadership, situational leadership, and servant leadership. ¹¹

The content of the interviews showed that public health leaders, confronted with major shifts in the nature of ill health

and growing diversity within health professions, have to make decisions in an increasingly complex environment. To add a further layer of challenge, globalisation and the economic crisis significantly impact on public health functions and how to operationally deal with existing and emerging health problems. These problems establish a strong mandate for public health leaders to develop more proactive health service models. Public health leaders need horizontal, alliance-based leadership, allowing them to work closely with stakeholders at all levels of society to effectively meet the challenges of population health and well-being. They should be driven by values of social justice, equity, honesty and responsibility, coupled with expertise, ability to discern trends in the midst of complexity and to capitalise on those trends by creating smart, adaptive strategies in an evolving environment.

Public health leaders demand leadership skills and behaviours that value decision-making by inclusion, collaboration and the broader participation of interdisciplinary health care teams engaging all members in shared leadership roles and collaborating with publicly-led health and equity related campaigns. Today's leaders need to be enablers and facilitators who support groups in creating and achieving shared goals. This principle of leadership is reflected in the notion of empowerment that is central to health promotion: enabling people to improve their health and address its determinants. Such an approach reflects transformational leadership, in which power for change is based on goals that serve a higher purpose, in this case better health and wellbeing as a societal goal. This is the essence of the new framework for European public health leadership.

Public health leadership training: a vision for the future

Since leadership, in general, is still not common at undergraduate, postgraduate and CPD level of public health education, there is a need for providers of public health training to practically develop more progressive curricula which incorporate leadership.

CPD options may be optimised if they are collaborative, interdisciplinary, inter-professional as well as global and digital. The CPD course LEPHIE delivered by Maastricht University* and developed in collaboration with ASPHER, can serve as an example of such a training course targeted at busy public health professionals. Bearing in mind that the key to differentiating leadership in public health from other areas is the context, this course includes current meaningful public health problems and challenges which participants try to solve by using problem-based learning methods. Participants take responsibility for and plan their own learning as they construct or reconstruct their knowledge. Learning becomes a collaborative process by sharing a common goal, responsibilities, and learning needs through open interaction. The content of the course is based on the Public Health Leadership Competency Framework, which also serves as a self-assessment tool in executive coaching which supports individual leader development and is an indispensable part of training to produce effective public health leaders.



In developing the content of other new public health leadership courses, a starting point may be to identify the competency capacities of future leaders in relation to population health and well-being and apply the results of the interviews with public health leaders to inform education, training and culture change throughout public health workforce. Topical cases, active and inquiry-based learning processes should be at the heart of the learning experience. Participants should be encouraged to engage directly with community organisations and draw on the knowledge sources that inform public health theory, policy and practice. Blended learning – a combination of face

to face, print and information technology – is encouraged as it supports busy professionals interested in developing their expertise through CPD¹¹ and facilitates transformational learning for health equity.

However, the question remains: who should take responsibility for the development of public health leadership that is fit for purpose, accessible and supports the career development path of public health leaders?

Developing public health leadership capacities

It seems that there is a strong awareness among the public health professional community – supported by targeted policies such as the *Health 2020* and the *WHO European Action Plan* about the importance of developing public health leadership to tackle health inequities and inequalities. Moreover, WHO Essential Public Health Operations (EPHOs) form a framework for the entire public health system. In particular, EPHO No. 7 on *Assuring a sufficient and competent public health workforce* is a key operation for WHO to promote strategies supporting the development of a public health workforce. At the same time, it provides a mandate for developing the adequate and modern training in which public health leadership can play a prominent role.

In 2013, the WHO Regional Office for Europe delegated responsibility to ASPHER to lead its working group on EPHO No. 7. The development of a public health workforce and shaping the public health profession is a key action area focusing on preparing the public health disciplinary cluster to face and respond to the health and health care challenges of the 21st Century.¹² In this area, WHO and ASPHER concentrate on collaboration to develop comprehensive educational strategies for public health based on the systematic mapping of member states' workforce capacities. With direct access to public health schools and departments, the development and adaptation of public health leadership programmes as well as leadership competencies have significant potential for success.

* <http://www.maastrichtuniversity.nl/web/Main/Sitewide/Agenda1/LeadershipCourseForPublicHealthInEuropeLEPHIE1.htm>

Conclusion

The development of strong and effective public health leadership is essential at all levels. There are examples of public health leadership training approaches supported by innovative IT and leadership competency models which can be adjusted to specific contexts and illustrated by real-life problems reflecting the struggles of public health communities. The commitment of key stakeholders in the area of policy, education and practice to support public health capacities is in place. Therefore, the question remains on how far new public health leaders will be willing and able to go in order to tackle pervasive and enduring health inequalities, particularly in view of the new post-election political landscape which may see an increasingly conservative and Euro-sceptical shift.

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Facets of public health in Europe

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In the last two centuries, public health has reduced the impact and prevalence of infectious diseases, but much remains to be



done to reduce noncommunicable diseases, such as heart disease and cancer, which comprise the bulk of the disease burden on the WHO European Region. This book takes a broad but detailed approach to public health in Europe and offers the most comprehensive analysis of the Region available. It considers a huge range of key topics in public health.

In addition, the authors consider the existing public health structures, capacities and services in a range of European countries, identifying what needs to be done to strengthen action and improve outcomes for public health.

Reflecting the broad geographical scope of the entire WHO European Region, this book uses examples from a diverse range of countries to illustrate different approaches to public health. It is essential reading for anyone studying or working in the field of public health, especially those with an interest in European practice.

Contents: Introduction; The changing context of public health in Europe; Monitoring the health of the population; The health security framework in Europe; Occupational health and safety; Environmental health; Food security and healthier food choices; Health care public health; Screening; Health promotion; Tackling the social determinants of health; Intersectoral working and health in all policies; Health impact assessment; Organization and financing of public health; Developing the public health workforce; Developing public health leadership; Public health research; Knowledge brokering in public health; Drawing the lessons.

WE CARE: COORDINATING THE DEVELOPMENT OF AN R&D ROADMAP

By: Inger Ekman, Karl Swedberg, Reinhard Busse and Ewout van Ginneken on behalf of the WE CARE partners

Summary: How will a European high quality health care system – that can be afforded by society and still capture the inevitable societal, medical and technical progress – look like in twenty years? The WE CARE project coordinates the development of a new roadmap for Research and Development (R&D) towards 2035 to achieve a breakthrough in increasing health care costs while maintaining quality of care. The project challenges the European scientific community, policy makers and other key players within and outside the health care field to get involved and looks into current R&D, recently implemented cost containment strategies, and barriers to implementation.

Keywords: *R&D, Cost Containment, Quality of Care, Implementation*

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Note: WE CARE is a two-year funded project by the European Union within the 7th Framework Programme. More information on the project and the partners can be found at: <http://www.we-do-care.eu/>



Introduction

Across the European Union (EU), there is a clear and urgent need to curb health care costs. Health care spending in the five largest economies of the EU has grown by 27% from 2005 to 2010.¹ The situation is equally alarming in other EU Member States. The societal and economic impact of this trend is enormous, jeopardising the affordability and accessibility of health care to all EU-citizens. The biggest challenge is to capture the constant development of health care, to improve quality, and at the same time to contain increasing costs. This should ensure that all EU citizens have equal access to future health care, not only those who can afford private solutions. This is simply a democratic issue. However, where the current European research and policy agenda addresses this issue, it is most

often under the labels of “increasing efficiency” (such as changing payment systems towards capitation or diagnosis-related groups) or “value-for-money” (such as health technology assessment – HTA), but not overall cost containment.

The scientific problem

Containing costs and improving health care quality are often viewed as conflicting aims. R&D and innovation within the health area over the past twenty years has led to significant improvements in health care but generally have not contributed to curbing costs or keeping health care sustainable and affordable. Moreover, in current research funding, not much attention is given to cost containment at the macro level.

Figure 1: The multi-disciplinary competences of the WE CARE partners

Source: Authors

Technological, pharmaceutical and service-line innovations potentially result in better health outcomes and possibly more ‘value for money’. Unfortunately, reality often shows that instead of more ‘value for money’, the aggregate costs of health care provision to European citizens increase.² This increase is primarily caused by the reactive mechanisms in the entire health care system and its environment: 1) HTA looks at the cost-effectiveness of innovations, but is limited to available evidence which often concentrates on patients with high ability to benefit; 2) after the innovation is included in the public benefit baskets, it is also “inappropriately” applied to patients in which it may not be cost-effective; 3) this increase in the number of patients is fuelled by higher efficiencies of providers, made possible by other reforms such as new forms of payment; and 4) savings are thus not translated into macro level savings (i.e. lower total expenditure on health care) but end up as extra revenue in the hands of the providers.

Therefore, the challenge for WE CARE is to define a new strategic plan and R&D roadmap that embeds clear and viable plans on how science/R&D can facilitate a breakthrough in cost containment while, at the same time, improving the quality of care (which not only considers efficacy in clinical studies but also actual provision, including the appropriateness of services).

Due to the complexity of the health care sector, fundamental knowledge of institutional mechanisms, systems, methods and paradigms for change are needed. The challenge is enhanced by the fact that a multi-disciplinary approach is a pre-condition to change. The different scientific fields are too intertwined to allow for a mono-disciplinary approach. Cross-sectoral collaboration is therefore crucial in opening and supporting the innovative potential of non-health care disciplines to the benefit of the health care sector.

The mechanisms behind the increase in cost are complex and not well understood. For instance:

- Demographic change and increases in chronic diseases play a role, but are not dominant.
- The health sector is highly fragmented and organised along different sectors, disciplines and (with regard to R&D) diseases. Even though individual participants within the sector might take limitation of costs into consideration, many aspects hinder change and prohibit a breakthrough in containing costs.
- Technological innovations play an important role and can lead to substantial cost reduction but can also lead to increased expenditure (see above).

- The financial mechanisms for reimbursement, institutional settings, the culture within the sector, and the lack of a shared responsibility amongst participants may cause deficits in the national health care budgets across the EU.

Is there potential for cost savings?

IBM published the results of a survey of 518 economists³ and concluded that the health sector (with an estimated system value of \$4.27 trillion (€3.2 trillion) has the highest percentage of inefficiency – estimated to be above 40%. This is in line with the estimate by Berwick and Hackbarth⁴ for the United States of around one third. Of this inefficiency, the surveyed economists estimated that nearly 35% (or c. 15% of total expenditure) could be avoided, leading to savings or providing room for improvement – while the analysis of the American scenario suggested that the reduction of inefficiencies could be used to keep health expenditure at 17.5% of Gross Domestic Product (GDP) stable for the next decade (instead of growing to more than 20% by 2020). Examples of challenges in future health care are multi-fold.

“multi-disciplinary approach is pre-condition to change

Often discussed is the person-centred approach where care is tailored together with each patient – in contrast to a personalised medicine approach where every patient’s unique features are measured down to proteins and genes. As both options are in progress, there is a need to define the values of these approaches and to find out how they can be combined and optimised. Although there is substantial evidence on the direct effects of policy efforts towards cost containment in health systems, it tends to be focused on single policies, often

in specific settings and whether macro level cost containment is achieved often remains unclear.

The WE CARE project

The WE CARE project is a two-year project funded by the European Commission's framework programme FP7. The WE CARE Consortium is set up in a very diversified and multifunctional fashion with seven partners. The mission of WE CARE is to coordinate the development of a new Strategic plan and R&D roadmap on cost containment of health care with maintained or even improved quality, by stepping-up coordination between EU key players (see Figure 1). This will be accomplished by inviting EU key players from politics, industry and academia to participate in the project and to contribute to the development of the strategy plan and a R&D roadmap for 2035, which should become part of the EU's future health research.

In a multidisciplinary environment, different options to improve health care quality and at the same time contain cost will be explored. This will cover diverse areas of the health care system, like organisation of health care on a micro level, the use of technology, efficient policy-making and optimal reimbursement

systems. Workshops will be held during 2014 with the goal to define a number of R&D gaps that can be included in the roadmap. In the meantime, the consortium welcomes posts and comments on the online Forum. On 14–15 April 2015, a congress will be held in Gothenburg to discuss and synthesise the results of the WE CARE project and to finalise the Strategy Plan and R&D Road Map for the future EU HEALTH R&D programme.

Conclusion

The economic and societal relevance of this action is enormous due to the high impact of health care costs on national governmental budgets. If no breakthrough in cost containment will be realised in due course, health care could become unaffordable for many citizens within EU Member States. Therefore, health care systems in Europe need to be realigned and innovations to control costs need to be developed while maintaining, or even improving, quality of care. The question is not whether this needs to happen, but how it should be achieved. WE CARE hopes to provide a forum for all involved stakeholders and make some important first steps in drafting a European R&D roadmap for 2035.

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New HiT on Croatia

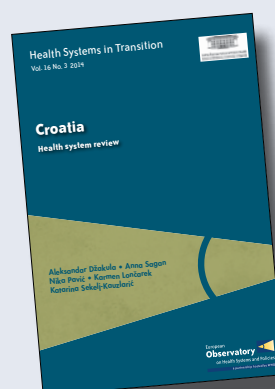
By: A Džakula, A Sagan, N Pavić, K Lončarek and K Sekelj-Kauzlarić

Copenhagen: World Health Organization 2014 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

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On 1 July 2013 Croatia became the 28th Member State of the European Union, after over three decades of political and economic transformation. In the years before accession, Croatia implemented a number of important reforms in the health sector, including changes in payment mechanisms, pharmaceutical pricing and reimbursement as well as health care provision (emergency care reform). The most important one was the 2008 financial reform to address long-standing problems of hospital deficits.

However, continued reform effort are necessary, especially as the EU, alarmed by the recent deterioration of Croatia's economy, has put it under increased budgetary scrutiny. Recently, the European Commission urged Croatia to strengthen its cost-effectiveness, especially in the hospital sector, which still is fraught with inefficiencies and remains a key source of debt in the system.



This mounting pressure may further spur the implementation of the Government's 2012-2020 National Health Care Strategy, which sets out reform priorities for the health care sector, such as coordination between various levels of care as well as improving quality and accessibility of care across regions.

CARING FOR PEOPLE WITH MULTIPLE CHRONIC CONDITIONS IN EUROPE

By: Verena Struckmann, Sanne Snoeijs, Maria Gabriella Melchiorre, Anneli Hujala, Mieke Rijken, Wilm Quentin and Ewout van Ginneken

Summary: Until recently, multimorbidity has not received much attention from European policy-makers. This is changing now that it has become clear that the number of people with multimorbidity is rapidly increasing. The ICARE4EU project will help to improve, analyse and disseminate innovative patient-centred multidisciplinary care programmes or practices for people with multiple chronic conditions in Europe. Early project results show that although policy-makers are increasingly aware of the challenge of multimorbidity, national policies and strategies focusing on these patients have not yet been developed. Nevertheless, various types of multimorbidity programmes or practices have been implemented in all four countries under study.

Keywords: Multiple Chronic Conditions, Multimorbidity, Integrated Care Practices, Finland, Germany, Italy, The Netherlands, ICARE4EU

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The ICARE4EU project (2013–2016) aims to support the European Innovation Partnership on Active and Healthy Ageing and is co-funded by the Health Programme 2008–2013 of the European Union. More information on the project and its partners can be found at: <http://www.icare4eu.org>



Multimorbidity – the challenge for care delivery in Europe

Currently, an estimated 50 million (mostly older) people in the European Union (EU) live with multiple chronic diseases.¹ This deeply impacts on their quality of life, not only physically, but also mentally and socially. Until recently, multimorbidity – the occurrence of more than one chronic disease within an individual – has not received much attention from European policy-makers. This is changing, now that it has become clear that the number of people with multimorbidity is rapidly increasing. Indeed, the European Commission started a European Innovation Partnership on Active and Healthy Ageing in 2012, in which care integration and multimorbidity

are explicitly addressed, while the World Health Organization recently launched a roadmap on a framework for action towards coordinated/integrated health services delivery.

The ICARE4EU (*Innovating care for people with multiple chronic conditions in Europe*) project² is an initiative co-funded by the EU's Health Programme 2008–2013, which will help improve, analyse and disseminate innovative patient-centred multidisciplinary care programmes for people with multiple chronic conditions. In a previous article published in the 2013 *Eurohealth* Gastein edition,³ we discussed the multifactorial challenges that chronic illness care places on European health

systems. The key question is how to respond to this increasing demand for comprehensive multimorbidity care. Integrated care models have been seen by many as a solution to overcome this question by taking a holistic approach while making efficient use of resources.

This article describes some early results from our project.^{7 8 9} We first describe whether national policies exist for chronic illness care, and more specifically multimorbidity care, and/or integrated care in four countries: Finland, Germany, Italy and the Netherlands. Furthermore, we introduce some first results of our survey among country experts by providing some examples of innovative integrated care programmes for patients with multiple chronic conditions in these four countries.

“lack of national policies”

The policy response to multimorbidity

While policy-makers across Finland, Germany, Italy and the Netherlands are aware of the challenge of chronic diseases and multimorbidity, national policies specifically focusing on patients with multimorbidity have not yet been developed. Italy is the only country, where regional policies on multimorbidity management have been formulated (e.g. by the Chronic Related Group, and by the Expanded Chronic Care Model).^{7 8 9} In Germany, Italy and the Netherlands disease specific policies focusing on chronic diseases exist; however, these may not meet the special needs of multimorbidity patients. All four countries have developed policies aiming at better integration of care. While these do not explicitly target patients with multimorbidity, they often contribute to improved care for these patients as well.

Care practices addressing multimorbidity

Despite the lack of national policies specifically addressing multimorbidity, care practices focusing on multimorbidity care or management have been developed and implemented within the four countries. Overall 25 care practices or programmes* have been identified in the study so far. In **Box 1** we provide two examples from each country in the study so far. Most are limited to the local or regional level, focusing on daily patient care. Regarding the multimorbidity orientation, several programmes in Finland, Germany and the Netherlands focus on multimorbidity in general. Other programmes are aimed at a specific diagnosis with a variety of possible co-morbidities or at a combination of specific chronic diseases.

The programmes display similarities with regard to process and quality related objectives, such as improved care coordination, increasing multidisciplinary collaboration and the promotion of evidence-based practice. In Germany, Italy and the Netherlands programme objectives were similar and focused on utilisation and costs, prevention/reduction of over-use of services and reduction of acute care visits. Most programmes address patients and/or medical care providers as target groups. The main care providers involved in the programmes across all four countries are general practitioners (GPs) and medical specialists. Overall, the number and disciplines of medical specialists participating in the programmes vary greatly. In Finland, multi-professional development groups have been established to enhance integration and collaboration at a practical level. Most programmes involve hospitals and primary care practices. Overall, the programmes vary according to the level of integration of care, especially with respect to the number of medical specialists and health care professionals involved.

So far, the impressions of country experts and programme managers regarding programme outcomes are generally positive and some programmes have

already been evaluated. For instance, in Germany the programme *Gesundes Kinzigtal* had been evaluated on its processes, outcomes, long-term effects and cost-effectiveness. For the programmes that have not been evaluated thus far, evaluations are planned. For this purpose data on several indicators are collected regularly within the programmes (monitoring), so that quality information will become available for evaluation purposes.

“programme outcomes are generally positive”

Conclusion

While policy-makers across Finland, Germany, Italy and the Netherlands are aware of the challenge of multimorbidity, national policies specifically focusing on multimorbidity care or management have not been developed as yet. Nevertheless, the implementation of multimorbidity care practices is increasingly considered to be an important issue in these four countries. The current care practices or programmes addressing multimorbidity that we described in this article vary with regard to their target groups, care providers involved and especially their level of collaboration and integration. There is great value in making an inventory of such integrated care programmes addressing multimorbidity for all European countries and by doing so providing a rich dataset to better study their features, factors and conditions for successful outcomes and implementation, as well as their transferability to other European regions or contexts (e.g. patient groups, health care systems). The next step in the ICARE4EU project aims to do so by identifying good practices, based on survey data from 31 European countries and related to four main perspectives, namely their patient centredness, the use of e-health technology, their ways of financing and management and professional integration issues.

* We do not assume that all available (eligible) care practices or programmes in Finland, Italy, Germany and the Netherlands were identified.

Box 1: Characteristics of programmes addressing multimorbidity in four countries

Programme	Main objectives	Target group	Care providers / organisations	Results
Finland PIRKKA-POTKU incl. care pathway for patients with multimorbidity, A regional sub-programme of POTKU (see above) in Pirkanmaa area.	<i>Process</i> e.g. Improving care coordination, improving integration of different organisations, increasing multi-disciplinary collaboration <i>Patient outcomes</i> Improving functional status <i>Utilisation and cost</i> e.g. Preventing or reducing over-use of services, reducing emergency/acute care visits, reducing (public) costs <i>Access</i> Reducing inequalities in access to care and support services <i>Patient centredness</i> e.g. Identification of target group patients, improving patient involvement	Patients with multimorbidity or patients who use a lot of services from many organisations or clinics. In particular patients whose needs are not met by the services, who need proactive care planning or who need long-term care.	Health centres, patient organisations, GPs, informal carers, district/community nurses, physiotherapists/exercise therapists.	Evaluated internally; objectives mainly reached. The programme has supported integration of care services, collaboration between care providers, competencies of care providers, patient centredness, patient involvement, involvement of informal carers, use of e-health tools and cost-effectiveness. Closer collaboration between public health care and patient associations and patients are now included in the development of care.
Finland Chronic Care Model for Patients with Multiple Diseases in Primary Care.	<i>Process</i> e.g. Improving professional knowledge on multimorbidity, improving care coordination, increasing multi-disciplinary collaboration <i>Patient outcomes</i> e.g. Improving early detection of additional/comorbid diseases, decreasing/delaying complications, decreasing mortality <i>Utilisation and cost</i> e.g. Preventing or reducing misuse of services, reducing hospital admissions, reducing (public) costs <i>Access</i> Reducing inequalities in access to care and support services, improving accessibility of services <i>Patient centredness</i> Identification of target group patients, improving patient involvement	Patients with multiple chronic diseases and patients with cardiovascular diseases dementia, asthma/COPD, rheumatoid arthritis, depression, atrial fibrillation, osteoarthritis, etc.	Primary care practices, health centres, patient organisations. GPs, many medical specialists, district/community nurses, physiotherapists/exercise therapists, dietitians, psychologists/psychotherapists.	Evaluated internally; objectives mainly reached. The programme has promoted integration of care services, collaboration between care providers, competencies of care providers, patient-centredness and patient involvement. The care model is a useful tool for staff. From one portal the professionals can find everything they need to follow up with a patient with chronic diseases. The model is multidisciplinary and provides patient empowerment.

Box 1: Characteristics of programmes addressing multimorbidity in four countries (continued)

Programme	Main objectives	Target group	Care providers / organisations	Results
Germany Gesundheitsnetz Qualität und Effizienz eG Nürnberg Health network quality and efficiency eG in Nürnberg, the federal state of Bavaria	<i>Quality of care</i> Improving integration of different organisations, increasing multi-disciplinary collaboration <i>Patient outcomes</i> Improving early detection of additional/ co-morbid diseases <i>Utilisation and cost</i> Preventing or reducing over-use of services <i>Improving patient centredness</i> e.g. patient involvement	Patients with multi-morbidity in general, medical care providers, non-medical care providers and management.	General hospitals, primary care practices, nursing homes, policlinics, patient organisations, social care organisations, physiotherapy, self-help and GPs and several medical specialists, namely: cardiologists, surgeons, internists, E.N.T. specialist, pulmonologist, etc.	The programme suggests improved coordination of care, improved cooperation between medical and non-medical care, staff and patient satisfaction, better patient involvement, changes in utilisation of resources, cost savings and it is transferable. The objectives set in the programme were said to be completely reached.
Germany Gesundes Kinzigtal in Haslach in the federal state of Baden Württemberg	<i>Quality of care</i> e.g. Promoting evidence-based medicine, improving professional knowledge on multi- morbidity, increasing multi-disciplinary collaboration <i>Patient outcomes</i> Improving early detection of additional/ co-morbid diseases, decreasing complications, morbidity, mortality <i>Utilisation and cost</i> Reducing hospital admissions, (public) costs <i>Improving patient centredness</i> e.g. patient involvement.	The programme refers to patients with multi-morbidity in general, medical care providers, non-medical care providers and the population.	General hospitals, primary care practices, nursing homes, policlinics, patient organisations, social care organisations, pharmacy, insurer and management company. The programme involves several care providers such as GPs, cardiologists, internists, neurologists, etc., social workers, physiotherapists, dieticians and psychologists.	The programme improved integration of services, the collaboration of care providers and cost effectiveness. The objectives of the programme were said to be almost completely reached.
Italy ARIA Project	<i>Quality of care</i> Improving care coordination/integration <i>Patient outcomes</i> Decreasing complications/morbidity/mortality <i>Utilisation and cost</i> Preventing misuse of services <i>Improving patient centredness</i> Improving patient/informal carers involvement	Patients, informal carers and medical care providers. The programme specifically addresses people with physical disabilities (e.g. neuromuscular diseases, and chronic respiratory failure as comorbidity).	University and general hospitals, patient organisations. Care providers involved in the programme are medical specialists (pulmonologists) and physiotherapists/exercise therapists.	Results seem to suggest mainly improved integration/ collaboration of care services/providers, coordination of care, involvement/ satisfaction of patients/informal carers, etc. The programme seems also to be transferable. The results also suggest that the remote monitoring of fragile outpatients brings out physiological tranquility for patients and their caregivers.

Box 1: Characteristics of programmes addressing multimorbidity in four countries (continued)

Programme	Main objectives	Target group	Care providers / organisations	Results
Italy Renewing Health REgioNs of Europe WorkINgtoGether for HEALTH * * Multicentre Project involving the following European countries: Italy, Denmark (Lead partner), Norway Finland, Sweden Spain, Greece, Austria and Germany	<i>Quality of care</i> Improving care coordination/integration <i>Patient outcomes</i> Decreasing complications/mortality <i>Utilisation and cost</i> Preventing over-use/misuse of services <i>Improving access</i> Reducing inequalities and Improving accessibility in/to care and support services <i>Improving patient centredness</i> Improving patient/ informal carers involvement	Patients, informal carers and medical care providers. The programme generally addresses people with chronic diseases (e.g. heart failure, COPD, diabetes) aged 18+ years, and more specifically frail elderly people aged 65+.	University and general hospitals, primary care practices, nursing home, policlinic/ outpatient/ambulatory care, patient organisations, community/home care organisations, ICT departments, research institutes, regions and external providers. Care providers involved in the programme are GPs, medical specialists (cardiologist, pulmonologist, geriatrician and diabetologist) and different health professionals.	Results show mainly integration/ collaboration of care services/providers, patient/informal carers' involvement, staff/ patients/informal carers' satisfaction, changes in utilisation of resources (e.g. reduced hospitalisations), use of e-health tools and cost savings/ effectiveness. The programme is also transferable.
The Netherlands Guided Care Model – A disease seldom stands alone.	<i>Process</i> e.g. Improving professional knowledge, improving care coordination, increasing multi-disciplinary collaboration <i>Patient outcomes</i> Early detection of comorbidities, improving functional status, decreasing complications <i>Utilisation and cost</i> Reducing hospital admissions, reducing emergency care visits <i>Access</i> Improving accessibility <i>Patient centredness</i> Identification of target group, improving patient involvement, involvement of informal carers.	Patients aged 65 or older suffering from more than one disease or problem (physical, social, psychological, functional). Within this target group the following subgroups are specifically addressed: frail elderly, low health literacy, low income groups and people from deprived areas.	Involvement of primary care practices, health centres and centres of expertise in long-term care.	The Guided Care Model is an appropriate method for general practices. It enables care providers to manage the care for multimorbidity patients in a different way. Patients are positive about the increase in attention towards their personal health goals and the active support they feel they are receiving in reaching these goals.
The Netherlands INCA – the Integrated Care programme	<i>Process</i> e.g. Improving integration of different units, increasing multi-disciplinary collaboration <i>Patient outcomes</i> e.g. Early detection of comorbidities, decreasing morbidity <i>Utilisation and cost</i> Preventing over- and misuse of services, reducing hospital admissions, reducing (public) costs <i>Access</i> Reducing inequalities in access to care and support services <i>Patient centredness</i> Identification of target group, improving patient involvement	Patients suffering from diabetes, COPD and/or vascular risk management. Within this target group no specific subgroups are specifically addressed. Patients aged 18 years or older.	Involves primary care practices (general practice). Additional (medical/ non-medical) care sectors are involved according to patient needs. Research institute	The evaluation showed that the INCA approach helps to realise the shift from disease orientation to patient orientation. The harmonisation across health care standards/ disease management programmes (DMPs) provides a base for a more individualised (tailored) approach. The modular approach is key for further elaboration and application.

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Policy Summary on what is the evidence on the economic impacts of integrated care?

By: Ellen Nolte and Emma Pitchforth

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The rising burden of chronic disease, and the number of people with complex care needs in particular, require the development of delivery systems that bring together a range of professionals and skills from both the cure (health-care) and care (long-term and social-care) sectors. Failure to better integrate or coordinate services along the care continuum may result in suboptimal outcomes.

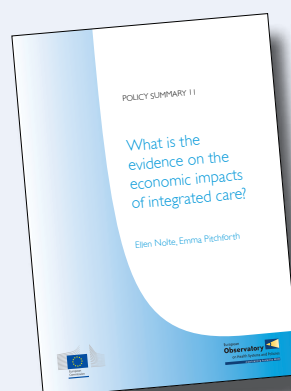
This Policy Summary analyses published reviews on the economic impacts of integrated care approaches. Given the wide range of definitions and interpretations of the concept, it proposes a working definition that builds on the goal of integrated care and which considers initiatives seeking to improve outcomes for those with (complex) chronic health problems and needs by overcoming issues of fragmentation through linkage or coordination of services of different

providers along the continuum of care. The review covers three economic outcomes: utilisation, cost-effectiveness and cost or expenditure and also looks at data on core health outcomes such as health status, quality of life or mortality, as well as process measures.

Available evidence of integrated care programmes points to a positive impact on the quality of patient care and improved health or patient satisfaction outcomes. However, uncertainty remains about the relative effectiveness of different system-level approaches on care coordination and outcomes, with

particular scarcity of robust evidence on the economic impacts of integrated care approaches. In addition, it is important to come to an understanding as to whether integrated care should be considered an intervention or whether it should be interpreted, and evaluated, as a complex strategy to innovate and implement long-lasting change in the way services

are being delivered and that involve multiple changes at multiple levels.



CSA PERMED: EUROPE'S COMMITMENT TO PERSONALISED MEDICINE

By: Lada Leyens, Erica Hackenitz, Denis Horgan, Etienne Richer, Angela Brand, Ulrike Bußhoff and Wolfgang Ballensiefen on behalf of the PerMed consortium

► #EHFG2014 **Forum 4:**
Personalised Medicine
2020

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Note: The CSA PerMed project (2013–2015) is funded by the European Union within the 7th Framework (No.602139) Programme. More information on the project and the partners can be found at www.permed2020.eu.



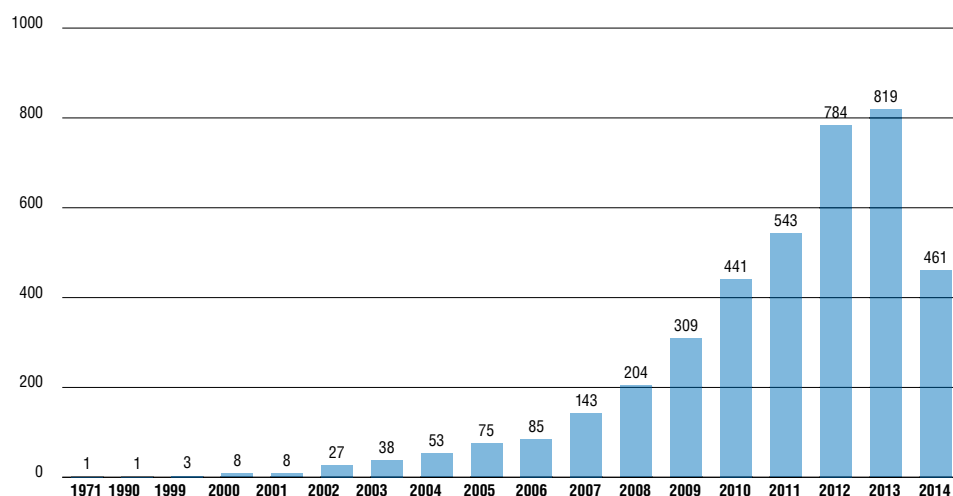
Summary: Personalised medicine is one of the most innovative areas in the future of health research. At present, its full potential cannot be developed due to fragmented activities, insufficient communication, and lack of generic solutions in the different areas of personalised medicine; moreover, implementation is a major challenge. The EU-funded Coordination & Support Action PerMed was initiated to step up coordination efforts between key European stakeholders, to allow synergies and avoid duplication or competition, and to provide recommendations to foster the implementation of personalised medicine in transnational research and health systems.

Keywords: *Personalised Medicine, Strategic Research and Innovation Agenda (SRIA), Europe, PerMed*

Personalised Medicine: present and future

Health care as we know it is radically changing to give way to increasingly more personalised health interventions for citizens and offering more personalised therapies and treatments for patients. Essentially, Personalised Medicine (PM) is an innovative method of treating citizens and patients that utilises research, data and up-to-the-minute technology to provide better diagnostics and follow-up for citizens than is currently the case. Among others, it uses genomic information to discern whether a particular intervention will work for a particular patient and assists clinicians in deciding which treatment will be the most effective. It can also have a huge impact in a preventative sense (see Box 1).

However, we are only at the beginning of the road and many challenges have to be overcome in order to benefit from PM's full potential. The era of 'one size fits all' in medicine is slowly coming to an end. Personalised treatment options are being developed for an array of conditions and some have already entered the market. Treatments for cancer are leading the field, but they are followed closely by treatments in cardiovascular, pulmonary, infectious and psychiatric conditions, among others. Personalised therapies aim to provide "the right treatment to the right patient at the right time", with early diagnosis, increasing efficacy, decrease in adverse drug reactions, and cost-effective treatments that may result in cost savings, quality of life improvement, and reduction of general morbidity in the population.

Figure 1: Number of publications per year on Personalised Medicine, 1971–2014

Source: PubMed, last search on 1 June 2014 with search terms “personalized medicine”- or “personalised medicine” in title or abstract.

Box 1: Definition of Personalised Medicine

“Personalised medicine refers to a medical model using molecular profiling for tailoring the right therapeutic strategy for the right person at the right time, and/or to determine the predisposition to disease and/or to deliver timely and targeted prevention.”

Source: Ref. 1

Despite being a concept already applied by Hippocrates more than two thousand years ago in Ancient Greece, the advances in the so-called “omic” sciences (genomics, transcriptomics, proteomics, metabolomics, etc.) and in Information and Communication Technologies (ICT) have led to enormous advances in the field of PM in the past two decades. Greater understanding of the molecular basis of disease and all the factors, such as environmental factors influencing disease onset, progression and response to treatment, together with the staggering fall in the costs of gene or genome sequencing and genotyping, plus faster results availability, have resulted in the market entry of over twenty personalised therapeutics; such as Herceptin, the first personalised treatment approved sixteen years ago for HER2+ metastatic breast

cancer. The development of many more is underway. However, the scope and approach of PM is not limited to the treatment of diseases only; it is much broader and inclusive, also covering areas such as lifestyle advice, prevention, environmental interventions and even the structure and organisation of hospitals and health systems. Furthermore, the increased interest from physicians, decision makers, regulators and the general public in PM has contributed to its increased application. **Figure 1** shows the number of publications on PM in the past 40 years, and their exponential rise particularly in the last ten years. Notwithstanding the great interest, we are still only at the start.

Although the US may have been leading the field in the past, Europe is showing a clear commitment to PM. Reports have been published by the European Commission (EC) supporting the mission of personalisation of health and many politicians and decision makers have expressed their support. For example, in the UK,² Germany³ and France,⁴ the national governments have made a strong commitment – implicitly or explicitly – to genomic medicine and the application of PM, mostly in cancer research and treatment. Furthermore, the EC’s new *Horizon2020* research grants programme – initiated in January 2014 – will promote research in all aspects of targeted therapies, including ICT to assist decision-making in PM. As the Director

General of DG Health and Consumers (DG SANCO), Paola Testori Coggi, puts it “it is essential for Europe to build on our strengths to develop innovations to promote growth and benefit European citizens. Genomics has the potential to be a key sector contributing to this in the future ... Advances in PM can bring business development and economic growth to Europe in addition to improved prevention, treatment and care to European citizens.”⁵ These objectives form the basis of CSA PerMed, otherwise known as the *Coordination & Support Action (CSA) Personalised Medicine 2020 and beyond* (see Box 2).

“still only
at the start

The development of PM in Europe represents an important paradigm shift for all health care systems and poses major challenges – both for the present and the future. These challenges need to be overcome to meet the objectives of *Europe 2020*, the *Digital Agenda*, the *Innovation Union* and *Horizon 2020*⁶ by bringing together: research for health, innovation for health and health equity, and significant contributions to global research and innovation systems. A general change in mind-set in health care delivery is also needed.

Realising potential benefits

Why should we strive towards the personalisation of health care and promote the four Ps in health (predictive and preventive, personalised and participatory)?

There are potential benefits from applying evidence-based personalised treatments, including:⁷

- improvement of informed medical decisions
- shift from reaction to disease towards prevention and prediction of disease
- targeted therapies with higher probability of success

Box 2: The PerMed consortium

CSA PerMed is a consortium – created by decision makers in Europe, including more than ten ministries and funding bodies – which aims to prepare Europe to be a global leader in the implementation of PM. It differs from other consortia and working groups due to the partners involved and its aim to carry out focussed discussions on concrete research actions, rather than prolonging on-going broad discussions and recommendations (see www.permed2020.eu). Moreover, transparency, openness, collaboration and the avoidance of duplication lie at the core of the CSA PerMed approach. The consortium's unique features create the potential to develop a strategic research and innovation agenda for Europe (SRIA) and be the starting point for a European Innovation Partnership (EIP) in PM acting across the entire research and innovation chain, bringing together key actors at European, national and regional level.

- risk reduction with fewer adverse reactions to medicines
- timely/early disease interventions
- cost-efficient treatment solutions and general health care cost containment.

For health systems as a whole, potential benefits include early systematic dialogue between the relevant key stakeholders, citizen-centred health care systems, encouragement of patients to be more active in their health management and feel greater ownership in the responsibility of their health, support quality of life, health and wellness, yield a maximum return on health care investment and adjustment to the needs of sub-sectors of the population, among others.

Nevertheless, a great deal still needs to be done to reach these benefits across the entire health care spectrum, and not restrict them to a limited number of conditions. The challenges have been

widely discussed and described in a large number of reports and publications (see next paragraph for examples).

The way forward

PerMed has identified and evaluated the information already available as well as the strategy documents published by key stakeholders, including reports, guidelines and roadmaps on PM. A gaps and needs analysis was performed on 18 relevant reports – from the EC,¹ the European Science Foundation (ESF),² the European Alliance for Personalised Medicine (EAPM),³ the Public Health Genomics European Network (PHGEN),⁴ the European Medicines Agency (EMA),¹⁰ the iNNOVAHEALTH Conference under the Cyprus EU Presidency¹¹ and the European Hospital and Healthcare Federation (HOPE)¹² among others – and over 35 interviews were carried out with relevant stakeholders.

“change
in mind-set in
health care
delivery

Regardless of their authors, interests and target group, these reports and interviews reach similar conclusions on the aspects that need to be tackled. These are:

1. Targeted research in molecular mechanisms and ICT

Targeted research to better understand the molecular mechanisms of disease and all implicated factors, as well as the identification and validation of biomarkers, is essential for the development of further personalised therapeutics. Multidisciplinary research teams, joining the knowledge from a variety of sciences, together with cross-disciplinary and cross-border collaboration in research and in drug development are essential parts of the R&D process of PM. Further developments in data collection, storage, management, sharing, mining, processing and analysis are also imperative. ICTs have not been exploited

to their full potential and will surely push forward the individualisation of medicine in all areas (research, translation, diagnosis, treatment decision-making, follow-up, etc.).

2. Adaptive business models, translational pathways and systematic early dialogue

The current business model for pharmaceutical companies is no longer valid once we move away from the “one size fits all” drugs. Pre-competitive collaboration between companies (pharmaceutical companies and medical device manufacturers, for example), the increase in public-private partnerships and a more flexible and adaptive business model is needed for the development and translation into health care of personalised technologies. Furthermore, systematic early dialogue with regulators and patients at an early phase of development would lead to more efficient drug development and translation processes. Clinical trial designs need to change: Phase III studies with thousands of patients are not possible and adaptive designs with smaller numbers of patients are needed, like the ones already being conducted in cancer that permit the application of personalised treatment options under one protocol. New dynamic and sustainable pathways that lead to timely and effective translation of innovative technologies into health policies and health care are needed, always ensuring high quality, safe and efficient treatments entering the market.

3. Make regulation simple, coherent and predictable

In addition, the regulations that are in place nowadays do not consider the specificities of personalised interventions, including therapeutics. Many of the ones that affect PM are being revised, but remain far from ideal. Especially in Europe – considering the inherited heterogeneity of our Member States – simplified, harmonised, coherent (across directives and regulations) and predictable regulatory procedures are welcomed. Some positive steps forward are the new medical devices directive regulating (for the first time in Europe) in-vitro and companion diagnostics, and the proposed adaptive licensing model from EMA.¹⁰ In order to expand its leadership role, it is

PerMed's view that Europe could engage in international efforts to harmonise regulatory aspects.

4. Driving health care systems towards preventive care

When it comes to health care systems, a general change in mind-set in health care delivery and provision is needed. From a coordinated reimbursement process for drugs and diagnostics, new financing strategies, new structures and models at the provider level, updated health care professional training and a change in attitudes, a shift towards preventive care, towards new cost assumption models, changes in patient behaviour and an increased interest and literacy from citizens in general are needed. The social consequences of the implementation of PM have not been fully studied, and there are many ethical challenges that lay ahead, which is why the principles of "Ethical, Legal and Social Implications" (ELSI) are essential and need to be further explored by research and applied by all stakeholders.

Conclusion

Even though PM may be one of the most innovative areas in the future of health research, the full potential for patients, citizens and the economy in Europe currently cannot be realised due to the inherited fragmentation between European Member States, inadequate communication and lack of common vision on the solutions that are needed. Appropriate governance levels are required to solve these challenges.

PerMed aims to provide concrete recommendations and to take a big step forward towards PM for all, without forgetting that the ultimate goal is to bring the right health intervention to the right patient at the right time, to avoid as many adverse reactions as possible during treatment, to make it affordable for health care systems and to ensure equality in access to personalised innovations. As long as the interests of citizens drive work towards this common mission, Europe can become a leader in PM, with the potential to also create business and economic growth and, most importantly, give

patients access to safe, highly efficient and targeted treatments in a timely and cost-efficient manner.

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SOLVING THE CONUNDRUM: HOW TO BALANCE **CARE COORDINATION** AND **PATIENT CHOICE** IN AUSTRIA?

By: Thomas Czypionka

Summary: Strengthening primary care is central to the ongoing health care reform in Austria, where patients can still enter the system at any point. Limiting this high degree of freedom is crucial for the reform to be effective. However, as it is much less popular to reduce choice than to extend it, the challenge health policy-makers are currently facing is considerable. Rebalancing care coordination, choice and voice in a multi-faceted approach might be a solution.

Keywords: Primary Health Care, Gatekeeping, Coordination, Patient Choice, Austria

Introduction

With the rise of chronic diseases, change towards providing evidence-based, continuous care across sectors has become a paramount goal for health care systems, including a strengthened primary care system to improve care coordination. However, this goal seems somewhat antithetic to the idea of a patient's freedom to choose any provider. Whereas in many countries, people are required to register with a general practitioner (GP) and to use him or her as the primary entry point, patients in health care systems like in Austria or Germany are used to having access to nearly any provider at any time. However, this comes at the cost of patients entering the care process at arbitrary points and impairs efforts to ensure coordination and continuity of care. Reducing this freedom for the "greater good" might be met with a lot of resistance by insurees as well as provider representatives and therefore might come at a high cost for health policy-makers.

Austria's health care system has been criticised for its fragmented, hospital-focused way of providing care for its population. The ongoing health care reform in Austria envisages a change towards strengthening primary health care (PHC), an area in which the country is traditionally weak, and a first concept was approved on 30 June 2014. Thus, decision makers find themselves in exactly the position of promoting new ways of service delivery that have the innate feature of reducing freedom of choice. After a phase of tiptoeing around the subject, they need to get more specific on the details as the design for implementation has to be drawn up.

The case of Austria

When, in 2012, policy-makers decided to implement a fundamental reform, they wanted to amend some of the traditional challenges with the Austrian health care system. In the outpatient sector, the prevalent form of care delivery is the

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single practice, with the physician as the only medical professional. Out-of-hours care is rarely provided in the GP sector, making the hospital a convenient entry point. There is no real PHC system in the sense outlined by Starfield et al.⁴ or the European Commission's Expert Panel on Investing in Health⁵ in terms of continuity or care coordination. The patient is free to enter the health system at a GP, a self-employed specialist, or a hospital. If he/she never does go to the doctor, in principle no one cares. Due to fragmented financing of acute care between social health insurance (SHI) and all levels of government, coordination of care efforts is usually poor. The somewhat paradoxical consequences are i) rather satisfied patients due to a menu of care options and few restrictions; ii) health care expenditures among the top five in Europe; and iii) only average outcomes for chronic diseases.

The ongoing reform emphasises the need for more preventive care, a true PHC system and refocusing care and corresponding funds by payers sharing the responsibility and funding rather than butting heads. However, there is still no clear position on how to cope with one of the less popular elements of the reform, the need to reduce freedom of choice in favour of more care coordination and continuity.

The costs and benefits of PHC

The case for PHC has been well made in the literature by Starfield⁴ and subsequent authors.⁶ Strong PHC means a lower threshold for comprehensive care for the population. This results in more timely interventions, better coordination and continuity of care for chronic conditions and better conditions for preventive efforts. These features of PHC have numerous beneficial effects: hospitalisations for many chronic conditions can be reduced; population health can be improved on several dimensions; while socioeconomic inequality is reduced. When it comes to the downsides of such a system, probably two things are worth mentioning. Countries with a stronger PHC system were found to have higher health care expenditures, albeit lower growth rates.³ Moreover, an innate feature of PHC is that people stay on the list of a GP and

by accepting him/her as the primary entry point to the health system they are effectively constraining their freedom.

“satisfied patients due to a menu of care options

When it comes to Austria, these effects can be perceived with one notable exception. Health care costs are among the highest in Europe, and introducing primary care in this case might actually drive down costs in the long run due to better allocative efficiency of spending, after a phase of investing in better primary care.

The costs and benefits of provider choice

Choice can be exerted on different levels. The first level is choice of insurer and choice of insurance plan (with its different subcategories), which is normally only potentially possible in insurance-based countries, with the exception of moving elsewhere in regionalised Beveridge systems. The second is choice of providers on different sub-levels, i.e. choosing a GP, a specialist, an integrated care programme, a treatment centre or a hospital for ambulatory or inpatient care. The third is choice with respect to treatment. However, we will first concentrate on provider choice as this is at stake when strengthening primary care.

A lot has been written about the costs and benefits of provider choice in the context of health care systems that consider expanding it,^{4,5} but less so for health care systems that probably need to reduce it in favour of patient guidance and how this can be achieved. While the freedom to choose providers is expected to increase their quality and efficiency through competition, these effects also hinge on some form of overcapacity and the availability of information as well as the ability of patients to process it. The latter requirement has sometimes led to

the perception of choice as inequitable, as it favours the better educated and well off. Then again, not giving anyone the opportunity to make an informed choice is not in itself beneficial.

Other arguments invoked are increased transaction costs, as can be seen in the overall higher health care spending of most SHI countries, where the feature of provider choice is normally built-in. In the context at hand, probably the most important downside of choice is the danger of fragmenting care. On the other hand, being able to choose a provider might also improve satisfaction and provide a better provider-patient fit.

Eventually, people just seem to “want” to be able to choose. For health care systems that offer free choice of provider, this fact seems to be the biggest policy challenge when attempting to increase care coordination.

Challenges in Austria

From discrete choice experiments (DCE) we know that people value choice quite highly when they are used to it (see for example a DCE for Germany and the Netherlands⁷). The reality test in the form of the *Hausarztmodell* in Germany or HMO/telemedicine-plans in Switzerland show that insurance companies have to compensate people for reduced choice with considerably reduced premiums and/or user charges. In fact, when not using considerable financial incentives (or probably even then), such initiatives are met with little enthusiasm.

But the preference not to give up (some) choice is only part of the story. Setting up a PHC system that lives up to the name requires a whole lot more than just giving up the possibility of self-referral to a specialist. Many failed attempts to improve care coordination by restricting provider choice seem clumsy in hindsight. Just by offering some monetary incentive or introducing user charges does not make people go where policy-makers want, especially if the attempts are indecisive. If visiting my GP first* is so beneficial,

* The point here also is that just visiting a GP as a formality prior to a specialist is not what strong primary health care is about.

then why is it voluntary and people try to pay me for it? Problems here seem to arise at least from three aspects: the prerequisites for, the process of, and the means used in the reform.

“what forms of choice really matter”

When it comes to prerequisites, it was probably underestimated in many cases how demanding a PHC system is. Making GPs gatekeepers does not make them better trained or allow them to acquire knowledge instantly about procedures for which they have previously referred patients to a specialist. Neither will patients believe this is so, and even less so after having been told for decades that specialists provide better care. Self-employed specialists depend on self-referrers for income and have gotten used to being bothered with minor problems that are treated by GPs in other countries. In addition, outpatient departments in hospitals have expanded their capacities to receive many people who are simply unwilling to make an appointment outside, and while complaining about the encumbrance, hospital management remains reluctant to move services and funds to other providers. In other words, in countries like Germany, France or Austria, there is simply no tradition, no culture and no institution that would ready these countries for the quick introduction of true PHC.

The underestimation of these institutional factors also seems to be an explanation for the fact that the process of reform in these countries might not always have been up to the challenge. When France, in 1998, shyly introduced the option for insurees to enrol in a gatekeeping system connected to financial incentives, uptake was very poor.⁹ In Germany, the *Hausarztmodell* is still contested by many and far from the success it was expected to be.⁹ What is even more striking is the timeframe of these reforms. Institutional change can only be achieved over extended periods of time, but reforms often seem

goal-oriented, trying to implement the state of the system envisaged rather than implementing the change needed to attain this state in the future.

The means to introduce more care coordination have also been quite simple despite the experience that changes to complex systems need a bundle of measures to balance out its adaptations. The answer has often been to simply introduce gatekeeping, some disease management programme (DMP) and/or user charges to discourage other forms of care use. In 2000, Austria introduced user charges for outpatient departments in hospitals (*Ambulanzgebühr*) as a singular measure, which was abolished the same year. In contrast to Austria or Germany, France found itself with the comfortable solution that it relies on in-cash benefits. In a second attempt to introduce a voluntary form of gatekeeping in 2004, the *médecin traitant* (a preferred provider system), reimbursement was severely cut for directly accessing specialists along with incentives for the common voluntary insurance schemes not to cover this form of user charge.

A more complex matter: provider choice and voice

While Hirschmann⁹ started to draw our attention to the importance of voice and exit as a means to improve responsiveness more than forty years ago, the interaction of preferences in the population, different levels of choice and options to voice opinions is very complex. Nevertheless, the literature on the matter has begun to develop a far more differentiated look at what forms of choice really matter and what numerous ways there are to make oneself heard.

Many health care systems have tried to increase choice and/or voice and we can find a wide variety of combinations out there.¹⁰ While maintaining the gatekeeping-function of the GP, the UK gradually expanded choice of GP as well as choice on higher levels of care, similar to the Scandinavian countries. So instead of choosing between all providers, choice can be exerted when entering a new level of care.

Traditionally, these countries also engaged in some form of public involvement and strengthened patients' rights. The Danish, for example, conduct an annual patient survey and feed the information back to all levels of decision making. They also support patients with information on health related matters and quality of providers on www.sundhed.dk as well as through a system of patient counsellors. In England, the system's struggle for patient empowerment produced the NHS constitution. *NHS Choices* (online) and *NHS Direct* (replaced by NHS 111 since March 2014) provide information on a wide variety of topics including support to find the right provider and (unusually detailed) information on quality of providers. Local Involvement Networks are supposed to empower the public in matters of local health care, and the Care Quality Commission, while keeping a close eye on providers, also conducts numerous surveys that are expected to improve the system. In the Netherlands, with the quite unusual feature of gatekeeping in an insurance-based country, there is a strong tradition of public involvement and laws that emphasise the right to information and strengthen the position of patients and their representatives under the umbrella of the Netherlands Patients and Consumers Federation (NPCF), apart from choice of insurance company. Strong patient rights to information and involvement in the care process have been enacted. *Kiesbeter* is a website with similar information to its Danish or English counterparts. Insurers and providers are required to involve the public in their decisions through counsels and/or surveys, and the NPCF is also represented on national boards.

Naturally, not all of these activities work perfectly and much can be improved. However, these examples show how health systems try to handle the delicate balance between choice and voice.

A new balance is needed

Whether Austria really offers that much choice in the first place has to be scrutinised. People have no choice concerning their insurer, nor can they choose between different insurance plans. When it comes to choosing a provider,

the field is wide open, but information on medical issues (like patient versions of guidelines), services or quality of service provided is widely lacking compared to what is offered in countries like England or the Netherlands.

An imminent challenge for health policy in Austria is to find a new balance between provider choice and the introduction of a functioning primary care system. As always in such complex matters, bundles of measures rather than singular measures seem appropriate, and internationally we can find a lot of role models.

Austria could change the “choose between all providers” maxim to a “choose between the right providers” maxim. Choice can still be exerted, but only on each level of care separately, as is common in other countries. In addition to this, people should be empowered to make informed choices in the first place, by making available patient guidelines, more information on providers and a telephone service. Decision makers also have to ensure the quality of primary care providers, so people can trust them with their health. They also have to actively communicate the benefits of primary care to the population rather than leaving the field to the preservers of the status quo. When provider choice is limited to some degree in a new system, it is also important to make sure that *patients have a say in their treatment*. This is still far too uncommon in the rather paternalistic medical tradition.

On a more general level, there are many other ways to gauge the preferences of people. While introducing primary care, Austria can improve public involvement in the decision making process. The position of patient representatives and self-help groups with respect to providers can be strengthened. Furthermore, surveys can be used on a more regular basis to ensure that information is fed back to providers and decision makers.

While we can learn a lot from other countries to rearrange the balance between choice of provider and care coordination, the political process poses an immense challenge. A lot remains to be done to ensure the success of the ongoing health

care reform, but efforts should also be refocused. The health care system is not a machine, but a complex social system. Therefore, it seems to be necessary not only to implement the beneficial changes that are on the agenda. Before these seeds can take roots, the ground itself has to be more thoroughly prepared by measures that are aimed at changing institutional patterns.

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HEALTH SYSTEM TRENDS IN THE FORMER SOVIET COUNTRIES

By: Bernd Rechel, Erica Richardson and Martin McKee

Summary: Key trends in population health, the organisation and governance of health systems, health care provision and health financing in twelve former Soviet States are presented. The health systems in the region are still doing poorly in improving population health. Many of the post-Soviet countries are restricted in their ability to provide effective, timely and responsive care to those in need of it. One of the key prerequisites for making further progress is to move health higher up the political agenda.

Keywords: *Health Status, Health System Trends, Health Reforms, Former Soviet Countries*

Introduction

More than two decades have passed since the break-up of the Soviet Union in 1991. This momentous event changed the political geography of Europe, with many countries that were once part of the Soviet bloc eventually entering the European Union (EU) in 2004 and 2007, including the three Baltic states (Estonia, Latvia and Lithuania). The situation has been different for the twelve former Soviet states that have remained outside the enlarged EU (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan). Many of them are still beset with problems resulting from an unrealised reform agenda, as well as problematic socio-economic or political contexts. This article examines what has been happening in the health systems in these twelve former Soviet countries, summarising key elements of a newly published comparative analysis.¹

Health trends

The collapse of the Soviet Union was followed by one of the most dramatic drops in life expectancy in peace time. Declines were particularly pronounced among men in the Russian Federation, with male life expectancy falling by 6.2 years between 1990 and 1994, to just 57.6 years. Although declines were less dramatic in other countries of the region, as a rule, life expectancy dropped in the first half of the 1990s, with only a slow recovery since then. Overall, the gap in life expectancy with western Europe has increased over the past two decades. Worryingly, people in the region can expect to die much earlier than their counterparts in western Europe, even in those countries with economies that are booming thanks to the extraction of natural resources (Azerbaijan, Kazakhstan and the Russian Federation).

The main causes of death contributing to this persisting gap in life expectancy are circulatory system disorders (most notably ischaemic heart disease)

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and external causes such as injuries, violence and poisoning. In 2011, directly standardised all-cause mortality rates for under 65 years old per 100,000 population in the Commonwealth of Independent States (CIS) exceeded the EU average by a factor of three for males (801 and 269 per 100,000 respectively), while mortality rates were more than two times higher for females (308 and 131 per 100,000 respectively). Major risk factors include high alcohol consumption (in particular hazardous drinking of spirits and surrogate alcohols, i.e. substances including ethanol but not meant for consumption), high smoking prevalence, poor nutrition and poor access to effective health care. Other pertinent health problems include high (although decreasing) rates of tuberculosis and, in several countries, an increasing burden posed by HIV/AIDS.

“the gap
in life expectancy
with western
Europe has
increased

Organisation and governance

The organisation and governance of health systems in the region has also seen major upheavals in many countries, although some have been resistant to change. Several countries have experimented with the decentralisation of responsibilities, usually as a consequence of broader administrative reforms. Sometimes, this has exacerbated unclear divisions of responsibilities, leading to weak coordination and major inequities among regions. To varying degrees, parallel health systems from ministries or major state companies inherited from the Soviet period have persisted, resulting in duplication and fragmentation, undermining the effectiveness of the broader health system. Overall, the effective governance of health systems is undermined by a lack of quality data, lacking transparency and accountability, large informal sectors, the existence

of informal payments, underdeveloped systems to ensure patient rights, lack of awareness of entitlements, fragmentation across different tiers of government, insufficient regulation of the emerging private sector, and a limited involvement by the public and of professional associations in health policy development. In all these respects, the post-Soviet countries are restricted in their ability to provide effective, timely and responsive care to those in need of it.

Health care provision

Two major foci of reforms in health care provision in the post-Soviet period were attempts to downsize hospital sectors and, correspondingly, strengthen primary health care. The collapse in government health funding in the early 1990s necessitated reductions in the oversized hospital sectors inherited from the Soviet period. However, closures were often confined to small rural facilities, while few hospitals in urban areas were affected and politically powerful tertiary care facilities have remained virtually immune. Most countries in the region still have a higher ratio of acute care hospital beds per capita than EU member states and there is also still a much longer average length of stay. However, the lack of investment in modern technology, or if it is present, of using it effectively, coupled with the low status of nurses and some other health workers, limits the scope to improve productivity.

Far too often, patients are admitted to hospitals for the wrong reasons. In some countries of the region, patients are up to ten times more likely to be hospitalised for hypertension than in OECD countries, a condition that rarely requires hospitalisation in western countries.^[2] Other examples of conditions that are commonly treated in hospitals rather than outpatient facilities include tuberculosis, diabetes and drug addiction.^[3] Reasons for keeping patients in hospitals longer than necessary include weak gatekeeping in primary care, poor integration of care and perverse financial incentives for over-hospitalisation.^[4]

Strengthening primary health care was another key objective of health reforms

in almost all former Soviet countries, often supported by international agencies.^[5] Most commonly, however, the Soviet model of primary health care, delivered by doctors with only basic training and able to treat a limited range of conditions, has been retained and primary health care based on a model of comprehensive family medicine is confined to pilot sites. Exceptions are Kyrgyzstan and the Republic of Moldova. In general, progress in primary health care reforms has been slow. One challenge is that resource allocation still prioritises secondary and tertiary care. Weak gatekeeping and referral systems, poor integration of care, and low public confidence in primary health care are other problems. Primary health care facilities in rural areas also find it difficult to attract staff and to secure other resources.

Despite attempts to improve it, quality of care remains a concern at all levels of care. The reasons for poor quality are many but include a lack of investment in facilities and technologies (as noted above), problems with the pharmaceutical supply chain, inadequate training of health workers, underdeveloped patient rights, absence of systems for quality improvement, the paucity of locally generated evidence, limited access to the international literature, widespread out-of-pocket payments (encouraging expensive and unnecessary treatments), poor integration of different levels of care, and the persistence of incentives to hospitalise patients.^[6] Surveys have shown that only a very small percentage (less than 10% in many post-Soviet countries) of those with high blood pressure take necessary medications regularly,^[7] and treatment rates for those with elevated levels of cholesterol are even lower.^[8]

Health financing

Some of the most profound changes in the post-Soviet period have occurred in the area of health financing. Following the collapse of government funding for health in the early 1990s, private out-of-pocket payments have become common, both in the form of official co-payments and in the form of informal, under-the-counter payments. In 2012, the proportion

of government spending in total health expenditure was less than 50% in five (Georgia, Azerbaijan, Tajikistan, Armenia and Republic of Moldova) of the twelve post-Soviet countries considered here. This poses a serious challenge to equity, as out-of-pocket payments reduce financial protection, equity in finance, equity in utilisation and access to services.¹⁰

“quality
of care remains
a concern

Governments have responded to this new reality by defining benefits packages with limited scope and shallow coverage. Most often, outpatient pharmaceuticals are excluded and so they now form a major component of private health expenditure. A secondary analysis of household surveys in eleven eastern and central European countries found that expenditure on drugs accounted for as much as 75% of household spending on health in the Republic of Moldova and more than 50% in Kyrgyzstan, Tajikistan and Azerbaijan.²

Some countries (most notably Kyrgyzstan, the Republic of Moldova, and the Russian Federation) have instituted mandatory health insurance systems. These reforms have sometimes been the driving force for comprehensive reforms of health financing, designed to improve equity and efficiency.¹¹ Many countries are also adopting payment mechanisms used in western Europe, with case-based payment mechanisms for hospitals, while primary care is now predominantly financed on a capitation basis.

Conclusion

Health systems in the former Soviet countries still have a long way to go to reach the standards found in western Europe. Most fundamentally, they perform poorly in improving population health. This applies to both non-communicable and communicable diseases, as well as curative care and inter-sectoral public health actions. For more progress to be

made, it will be essential to afford health a higher priority on government agendas and push the reform agenda forward.

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ASSURING QUALITY OF INPATIENT CARE IN GERMANY: EXISTING AND NEW APPROACHES

By: Miriam Blümel, Dimitra Panteli and Ewout van Ginneken

Abstract: During the last 25 years Germany has put more emphasis on quality in the inpatient sector and has fundamentally revised the demands placed on quality assurance in hospitals. A new Act furthers quality assurance in health care by making hospital quality more transparent for patients and by establishing a new scientific institute. A potential task for the future Institute for Quality Assurance and Transparency in Health Care may be not only to develop quality measures, but also to monitor their implementation and to take action based on the results.

Keywords: *Quality, Inpatient Care, Hospital Payment, Diagnosis Related Groups, Germany*

Introduction

European health care systems all face the same challenge: assuring high-quality health care while at the same time containing costs. Quality of care is one of the most frequently mentioned goals of health care systems and ranks high on the European as well as on the global health policy agenda.¹ The introduction of measures aiming to achieve more cost efficiency, e.g. hospital payment through Diagnosis Related Groups (DRGs), to many, may appear diametrical to this quality objective. Against this background, the development of approaches assuring quality of care is of crucial importance in Germany and may hold lessons for other countries looking to improve hospital quality.

Quality assurance measures have already been legally required in Germany since the Health Care Reform Act of 1989. Yet,

the German health system's performance only ranked 25th in the WHO Health Report 2000, which initiated both extensive discussions and an increased focus on improving quality of care. Both the Statutory Health Insurance (SHI) Reform Act of 2000 and the SHI Modernisation Act of 2004 introduced new requirements for internal and external quality control in service provision, encompassing structural, process- and outcome-related dimensions of performance. The 2013 coalition agreement includes further proposals for various measures with a focus on the promotion of quality. Some of these have entered into effect with the Act to Further Develop the Financial Structures and Quality in SHI, which passed parliament on 5 June 2014.

This article aims to provide an overview of quality assurance measures in place in

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the German health system. To this end, we first describe the regulatory environment for quality assurance. Second, we explore the approaches to internal and external quality control in German hospitals. Third, we examine to what extent and how quality is publicly reported. Lastly, we discuss what benchmarking approaches are in use before finishing with new initiatives and conclusions.

“explicit
focus on quality
assurance

Regulatory environment for quality assurance

The Federal Joint Committee (*Gemeinsamer Bundesausschuss*) is the highest decision-making body in the self-regulation and governance system in German health care. Its main responsibility is to ensure the implementation of the legislator's demands in every-day practice (§ 92, SGB V). Its directives span the areas of ambulatory and inpatient care, dentistry and psychotherapy, reimbursement and provision of diagnostic procedures, pharmaceuticals and other therapeutic procedures as well as medical devices. They are binding once the Federal Ministry of Health has approved them. The Federal Joint Committee has an explicit focus on quality assurance through its Quality Assurance Subcommittee. Its focal points include mandatory measures for quality assurance at the federal level and the endorsement of its enhancement, internal and external quality control, as well as setting minimum volumes of services and postgraduate training obligations for medical specialists and psychotherapists.

Internal and external quality control
Quality control measures differ in content, form and enforcement. Quality management has been mandatory for hospitals since the SHI Reform Act of 2000. The Federal Joint Committee allows hospitals to choose their quality management tool freely, but stipulates the aspects to be included.^[2] Accreditation

for hospitals is voluntary. Most hospitals that apply for accreditation use the Cooperation for Transparency and Quality in Health Care (*Kooperation für Transparenz und Qualität im Gesundheitswesen – KTQ*) or the proCum Cert systems, which rely on an initial stage of self-assessment before evaluation by external auditors. As of June 2014, there were 489 hospitals with a current valid KTQ qualification. Interestingly, a survey published in 2011 contests the correlation between hospital accreditation status and patient satisfaction, despite the fact that accreditation is widely used as a quality endorsement and patient satisfaction is stressed in the criteria catalogues of both the KTQ and the proCum Cert systems.^[3]

Quality elements have also been incorporated in the contracting process of hospitals. Sickness funds use quality indicators to compare hospital performance in their negotiations with providers. For this purpose, the Federal Office for Quality Assurance (*Bundesgeschäftsstelle Qualität – BQS*) was established to assist the contract partners in choosing and developing quality indicators to be monitored as well as to collect, compile and analyse the data, and to make the findings available to individual hospitals in the form of reports and recommendations.^[4] In 2009, these health care-related tasks were transferred from the BQS to the AQUA Institute for Applied Quality Promotion and Research in Health Care.

Additionally, minimum service volumes to be provided by hospitals eligible for SHI funding were set for certain services by the Federal Joint Committee in 2002 and integrated into the contracting process. Contract partners, i.e. the former federal associations of sickness funds, the German Hospital Federation (DKG – *Deutsche Krankenhaus Gesellschaft*) and the Federal Chamber of Physicians, were required by law to develop a list of elective services (e.g. transplantation and bypass surgeries, neonatal intensive care units) in which there is a clear positive relationship between the volume of services provided and the quality of the health outcomes.

For the services, delivery of a predefined

minimum volume during the previous year has become a precondition for receiving a new contract in the next year.^[5]

The introduction of DRG-based payments for the hospital sector in 2003 highlighted the need for better documentation and procedure coding, as well as increased scrutiny of resource utilisation and quality of care. Hospitals are subject to external quality control also by means of a nationwide reporting mechanism. This falls within the remit of the Federal Joint Committee and has been implemented by the AQUA Institute since 2010. Each year, the Federal Joint Committee decides on the areas of care to be documented. Hospitals are mandated to collect information on all cases in these areas and send it to AQUA, as well as to state-level quality assurance bodies. AQUA processes and evaluates data from all hospitals and feeds the information back to the providers, thus enabling them to assess their own performance in comparison to others. However, external quality control mechanisms could be ineffective: a recently published study on the development of hospital service volumes reveals that the data in hospital performance reports often do not conform to administrative claims data. For example, in the case of hip replacement some hospitals reported fewer mortality rates than coded in the claims data.^[6]

Public reporting

Since 2005, each hospital is obliged to publish biannual performance reports addressing patients and their relatives but also with reference to practitioners and the general public. All hospitals contracted within the SHI system have to make these reports available to the sickness funds for online publication and to their visitors in hard copies. The reports have to follow a uniform structure provided by the Federal Joint Committee and include data on structure, process and outcomes of care. General information on the hospital, its administrative organisation and priorities need to be covered, as do department-specific data on diagnoses (following the ICD classification) and procedures (following the OPS classification). The reports also have to include information on the hospital's compliance with external control legislation and their participation

in related activities, their achievement of minimal volumes and continuing education, as well as the types of tools and mechanisms they use to enhance quality management. However, as mentioned earlier, the reports' accuracy is not subject to control mechanisms and, thus, in some cases may publish incorrect figures.

plans to
strengthen
quality by law

Public reporting on hospital performance is primarily based on the official biannual hospital reports, which are used by several platforms. For example, the White List (*Weisse Liste*) is run by the Bertelsmann Foundation in cooperation with the largest umbrella organisations of patient and consumer protection institutions. Its search engine allows patients to search for providers by diagnosis, intervention and geographic area. The indicators available for each search depend on the condition and/or procedure, but structural information, the number of patients per physician and nurse and the frequency of treatment of similar cases are always in place. Data on outcomes are more rare, but when available they are presented in a traffic-light format (green = within normal range/comparable to national average; red = beyond expected limits). Similar comparison platforms are also run by the AQUA Institute and certain sickness funds (*AOK-Gesundheitsnavigator*, *TK-Klinikführer*, *Kliniklotse*). The reported data are sometimes supplemented with the experience of the sickness funds' insured. The DKG runs the German Hospital Registry (*Deutsches Krankenhausverzeichnis* – DKV), which provides the option of searching according to quality criteria, documented in hospital reports in addition to geographic and diagnostic criteria.[■]

Benchmarking

The Federal Ministry of Health widely supported the concept of benchmarking in inpatient care between 2003 and 2007: it endorsed ten model projects that

aimed to improve inpatient care by means of inter-institutional comparisons and learning from best practice. An evaluation of these projects showed varying degrees of development during the funding period and no overall trend regarding patient outcomes.[■] The Federal Association of German Private Hospitals (*Bundesverband Deutscher Privatkliniken*) launched a new program for online public reporting called Quality Hospitals (www.qualitaetskliniken.de), which reports on clinical quality (process and outcome), patient safety and satisfaction as well as on the satisfaction of the referring physician. It uses administrative data, survey data and information from the statutory reports of participating hospitals and thus provides not only a useful tool for patients but also a comprehensive benchmarking platform for hospitals themselves.[■] Another benchmarking approach, based on routine data collection and peer review, is followed by the Initiative on Quality Medicine, which was launched as a collaboration between a group consisting of private hospitals, charities, university departments and not-for profit organisations (<http://www.initiative-qualitaetsmedizin.de/>). A recent survey pinpointed 53 benchmarking initiatives with differing levels of adherence to the plan-do-check-act (PDCA) cycle active in the German health system.[■]

New initiatives

Since the elections in September 2013, Germany is governed by a grand coalition of Christian and Social Democrats with Hermann Gröhe being the Federal Minister of Health. The coalition plans to strengthen quality by law as an additional criterion for decisions on hospital planning and payment. The Act to Further Develop the Financial Structures and Quality in SHI commissions the Federal Joint Committee to establish a new independent scientific institute: The Institute for Quality Assurance and Transparency in Health Care. To this end, the Federal Joint Committee installed a private-law foundation to become the responsible body of the new institute and will nominate its director (upon approval by the Ministry of Health). The institute's task is to develop indicators for quality assurance and documentation of quality of care. For this

purpose, it will be allowed to collect and analyse administrative sickness fund data and to publish advice.

Although not clearly stated in the Act, quality-related payment will receive higher priority in hospitals. Plans foresee, for example, that hospitals providing high-quality services could be excluded from the 25% payment reduction for increases in revenue budgets. Conversely, below average quality for individual services may, in the future, lead to larger payment reductions. Pay-for-performance has not yet been formally established in the German health system. However, the development of comprehensive quality assurance indicators stimulates outcome-related financing and payment for the future.

Conclusions

During the last 25 years Germany has put more emphasis on quality in the inpatient sector. Since the Health Care Reform Act of 1989, quality assurance measures are a legal obligation and through the SHI Reform Act of 2000 and the SHI Modernisation Act of 2004, the demands placed on quality assurance in hospitals and the ambulatory sector have been fundamentally revised. The new Act to Further Develop the Financial Structures and Quality in SHI furthers quality assurance in health care, not only by making the quality of hospital services more transparent for patients, but also by establishing a scientific base for the introduction of quality-related hospital payment. It is worth noting that quality assurance mechanisms are important, but only as long as they are actually used to improve health care quality. A potential task for the future Institute for Quality Assurance and Transparency in Health Care may be not only to develop quality measures, but also to monitor their implementation and to take action based on the results.

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New HiT on Germany

By: R Busse and M Blümel

Copenhagen: World Health Organization 2014 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

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In the German health care system, decision-making powers are traditionally shared between national (federal) and state (Land) levels, with much power delegated to self-governing bodies. It provides universal coverage for a wide range of benefits. Since 2009, health insurance has been mandatory for all citizens and permanent residents, through either statutory or private health insurance. Characteristics of the system are free choice of providers and unrestricted access to all care levels. A key feature of the health care delivery system in Germany is the clear institutional separation between public health services, ambulatory care and hospital (inpatient) care.

Since reunification various governments have implemented a number of important reforms in the German health sector, including changes in self-governing structures, financing

the statutory health insurance system, paying providers and assessing and reimbursing pharmaceuticals.

Today the German health care system has a generous benefit basket, one of the highest levels of capacity as well as modest cost-sharing. Expenditure per capita is high and access is good. However, the system also shows areas in need of improvement when compared to other countries and has low

satisfaction figures with the health system in general and issues around quality of care, if the outcomes of individual illnesses are analysed.

This new health system review (HiT) on Germany examines changes and reforms that have taken place and discusses challenges for the new government that came to power at the end of 2013.



NEWS

International

Health and safety at work: Strategic Framework sets out EU objectives for 2014–2020

On June 6 the European Commission published a new Strategic Framework on Health and Safety at Work 2014–2020. It identifies three key challenges:

1. To improve implementation of existing health and safety rules, in particular by enhancing the capacity of micro and small enterprises to put in place effective and efficient risk prevention strategies
2. To improve the prevention of work-related diseases by tackling new and emerging risks without neglecting existing risks
3. To take account of the ageing of the EU's workforce.

A number of different proposed strategic actions are set out to meet these challenges. They include further consolidating national health and safety strategies through, for example, policy coordination and mutual learning. Further, the framework recommends simplifying existing legislation where appropriate to eliminate unnecessary administrative burdens, while preserving a high level of protection for workers' health and safety. The importance of the enforcement of health and safe workplaces is made clear, with one proposed suggestion being to evaluate the performance of national labour inspectorates. Other actions include the provision of practical support to small and micro-sized business to help them to better comply with health and safety rules, including the use of web based risk assessment tools. The framework is also mindful of the need to take account of the ageing of the European workforce and to improve the prevention of work-related diseases. It also recognises the importance of developing better monitoring tools and reinforcing coordination with international organisations (such as the International Labour Organisation, the World Health Organization (WHO) and the Organisation for Economic Co-operation and Development.

The new Strategic Framework builds on the 2007–2012 EU Occupational Health and Safety (OHS) Strategy. 27 Member States now have a national OHS strategy, adapted to the national context and key priority areas. The new framework will be reviewed in 2016 in order to take stock of its implementation and to take into account the results of an on-going comprehensive evaluation of EU occupational health and safety legislation which will be available by the end of 2015.

More information on the new Strategic Framework at: <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52014DC0332>

WHO calls for stronger action on climate-related health risks

Measures to adapt to climate change could save lives around the world by ensuring that communities are better prepared to deal with the impact of heat, extreme weather, infectious disease and food insecurity. For example, changes in energy and transport policies could save millions of lives annually from diseases caused by high levels of air pollution. The right energy and transport policies could also reduce the burden of disease associated with physical inactivity and traffic injury. These were key messages discussed at the first-ever global conference on health and climate, which took place at WHO headquarters in Geneva from 27 to 29 August. The conference brought together over 300 participants, including government ministers, heads of UN agencies, urban leaders, civil society and leading health, climate and sustainable-development experts.

The environment and health sectors in the WHO European Region have a long history of collaboration, consolidated in 2010 through the establishment of the European Environment and Health Ministerial Board. Participants from the WHO European Region participated in sessions on policies, mechanisms and tools for building health resilience to climate change, issues in urban settings and the leveraging of environment and climate finance to strengthen health systems. European Working Group on Health in Climate Change (HIC) co-chairs, Louise Newport of the Department of Health, United Kingdom, and Jutta Litvinovitch of the Federal

Ministry for the Environment, Nature Conservation, Building and Nuclear Safety in Germany, made a statement stating that "climate change responses have been rather reactive, as was seen recently in the multiple floods hitting Europe this year. Advance planning for what climate change will likely bring is an important component of the health-in-climate-change response, so capacities need to be evaluated and actively developed." The conference aimed to pave the way for consideration of health and climate issues in the UN Climate Summit, held in New York on 23 September 2014.

More information at: <http://www.who.int/globalchange/mediacentre/events/climate-health-conference/en/>

New report: preventing suicide a global imperative

On 4 September WHO published "Preventing suicide: a global imperative". It reviews current data on suicide attempts and mortality. The report notes that suicide accounts for 17.6% of all deaths among people aged 15–29 years in high-income countries and is thus a leading cause of death among people in this age group. Globally, 8.5% of deaths among young adults are due to suicide. The WHO European Region includes 33 of the 54 high-income countries identified in the report and tackling suicide is a key element of the WHO Euro's Mental Health Action Plan and the European Commission supported Joint Action on Mental Health and Wellbeing.

The new report is available at: <http://tinyurl.com/ose3ser>

The European Mental Health Action Plan is available at: <http://tinyurl.com/kby82ma>

The Joint Action on Mental Health and Wellbeing is available at: <http://www.mentalhealthandwellbeing.eu/>

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